Actions &

for

Improving Performance of the Department of Defense Disability Evaluation System

system purpose • desired outcomes • actual outcomes • training • management information system

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PREFACE

The Disability Evaluation System (DES) is the Department of Defense management tool used to determine the disposition of a service member who develops a physical or medical condition that calls into question the member's ability to perform the duties of his or her office, grade, rank, or rating. A service member enters the DES when a medical evaluation calls into question his or her ability to meet medical retention standards to perform military duties. A member who does not meet medical retention standards progresses to a physical disability evaluation, which results in findings and a disposition decision.

The Principal Deputy Assistant Secretary of Defense (Force Management Policy) asked RAND to examine how training DES primary participants could help provide more-consistent disability evaluation results for similarly situated members of the military services. This report documents the requested DES training analysis and recommended changes in training along with other recommendations to improve system performance.

The findings in this report should be of primary interest to the Under Secretary of Defense for Personnel and Readiness, the Assistant Secretary of Defense for Force Management Policy, the Assistant Secretary of Defense for Health Affairs, the Assistant Secretary of Defense for Reserve Affairs, and the Secretaries of the military departments. This report should also be of interest, to varying degrees, to the Surgeons General, commanders of military treatment facilities, Medical Evaluation Board approving authorities, physicians who convene Medical Evaluation Boards, physicians who refer service members to Medical Evaluation Boards (referring physicians), Physical Evaluation Board (PEB) approving authorities, PEB members, PEB Liaison Officers (PEBLOs), patient administrators who support Medical Evaluation Boards and/or PEBLOs, PEB administrative action officers, appellate review board members, active component unit commanders and Reserve unit commanders who interact with the DES, and attorneys who represent service members during appeals before the Formal Physical Evaluation Board.

This research was conducted for the Under Secretary of Defense for Personnel and Readiness within the Forces and Resources Policy Center of RAND's National Defense Research Institute (NDRI). NDRI is a federally funded research and development center sponsored by the Office of the Secretary of Defense, the Joint Staff, the unified commands, and the defense agencies.

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SUMMARY

To serve in the United States military—the Army, Navy, Marine Corps, Air Force, or Coast Guard (when it is operating as a service within the Department of the Navy)—service members must meet certain medical and physical standards to perform duties appropriate to their office, grade, rank, or rating.

A medical evaluation may call into question a service member's ability to meet medical retention standards to perform military duties, at which point the member enters the Disability Evaluation System (DES). Service members who do not meet medical retention standards progress to a physical disability evaluation, which results in a disposition decision.

Primarily while undergoing medical and physical disability evaluations, the service member receives counseling regarding what to expect throughout all phases of the disability evaluation process, the significance and consequences of the determinations that are made, and his or her rights, benefits, and entitlements. A member who disagrees with the physical disability evaluation findings and decision may redress that disagreement through appellate review.

Appropriate personnel authorities accomplish final disposition of the service member's case by issuing orders and instructions to implement the determination of the respective military department's final reviewing authority. The service member exits the DES by returning to duty, separating (with or without compensation), or retiring for disability or length of service.

Title 10 of the U.S. Code (U.S.C.) establishes the basis for disability retirement and separation. The DES is the Department of Defense (DoD) management tool used to determine the disposition of a service member who develops a physical or medical condition that calls into question the member's ability to perform the duties of his or her office, grade, rank, or rating. The DoD assigns responsibility for developing policies to implement and manage the DES to three Assistant Secretaries of Defense—for Force Management, Reserve Affairs, and Health Affairs. All three Assistant Secretaries report to the Under Secretary of Defense for Personnel and Readiness.

Disability evaluation training was first recognized in 1992 as a significant factor affecting DES performance. At that time, a Department of Defense Inspector General audit determined that the DoD DES was not efficient or economical. The audit re-

ported that disability cases were not processed promptly and service members were incorrectly rated for their disabilities. The audit report noted, among other things, that military personnel who adjudicated disability cases were inadequately trained, resulting in inconsistent application of disability policy and the lack of formal training contributed to rating deficiencies. Several other reports likewise recommended that the Office of the Secretary of Defense (OSD) focus on training as a key intervention to improve the performance of the DES.

DoD disability policy documents also emphasize the role of training in achieving the DES goal of conducting physical disability evaluation in a consistent and timely manner. The policy documents assign responsibility for developing and maintaining (1) a program of instruction for the DES; (2) a program of instruction on the preparation of Medical Evaluation Boards[1] for physical disability cases to be used by military treatment facilities (MTFs); and (3) a program of instruction on the medical aspects of physical disability adjudication, to include the application of the Veterans Administration Schedule for Rating Disabilities (VASRD) for use by PEB adjudicators and appellate review authorities.

STUDY COMMISSION

In 1999, the Principal Deputy Assistant Secretary of Defense for Force Management Policy asked RAND's National Defense Research Institute to identify and recommend changes to the training provided to primary participants[2] of the DES to ensure consistent application of disability policy across and within the services.

Consistent application of disability policy is one means of addressing unwarranted variability in differential treatment of similarly situated service members. However, underlying the desire to reduce variability is the more fundamental objective of enhancing the DES's ability to accomplish its purpose and desired outcomes. As a result, the primary question addressed in this study became the following: How can changes to disability evaluation training and other management interventions improve DES performance?

This report addresses the following four specific research tasks for the Office of the Assistant Secretary of Defense for Force Management Policy that focus on improving the performance of the DES:

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[1]To avoid misunderstanding, we avoid using the acronym *MEB*, which is commonly used to mean three different things: the group of physicians who convene as a board, the narrative summary, and the complete disability case file. Instead, we use "Medical Evaluation Board" when referring to the group of physicians who convene as a board (including those who pass records among themselves without actually convening a board). We refer to the actual narrative summary as the "narrative summary" and the disability case file as the "medical board."

[2]For the purposes of this study, primary participants in the DES include the following: physicians who refer service members to Medical Evaluation Boards, generally known as referring physicians; physicians who convene Medical Evaluation Boards; Medical Evaluation Board approving authorities; PEB Liaison Officers (PEBLOs); patient administrators who support Medical Evaluation Boards and/or PEBLOs; PEB administrative action officers; PEB members; PEB approving authorities; post-PEB appellate review board members; active component unit commanders; Reserve unit commanders who determine eligibility for temporary incapacitation pay; and attorneys who represent service members during appeals before the Formal Physical Evaluation Board.

- describe a basis for assessing the performance of the DES
- identify issues affecting the current performance of the DES and interventions to resolve those issues
- analyze DES training needs and recommend changes in training to improve system performance
- develop a method for continuously monitoring performance of the DES over time.

STUDY APPROACH

To recommend changes to the training provided to DES primary participants that would ensure consistent application of disability policy across and within the services, we first identified a number of instances of variability in policy application across and within the military departments. We captured, and then analyzed, those instances of variability in the form of *issues*. We next employed an issues-driven, bottom-up "Goal Fabric" analytic methodology (discussed in Chapter 4) to identify actions needed to resolve the identified issues and organize those actions into an overarching plan to ensure consistent application of disability policy across and within the services. One of the ten categories of interventions that resulted from this approach was a training intervention that focused on resolving current performance issues.

In recognizing that consistent application of disability policy is just one means of addressing unwarranted variability in differential treatment of similarly situated service members, we also focused on overall DES performance. To focus on system performance, we employed a purpose-driven, top-down approach and developed a statement of purpose[3] and desired outcomes.[4] This approach and statement serve as guideposts for developing a comprehensive disability evaluation training intervention and a management information system to monitor the effectiveness of the recommended training program and overall system performance over time.

FINDINGS AND RECOMMENDATIONS

The major findings presented in this report cover four areas: (1) developing a basis for assessing DES performance; (2) identifying issues of variability in DES policy application and recommended interventions; (3) conducting a DES training analysis and recommending changes in training to improve system performance; and (4) developing a recommended method for continuously monitoring DES performance.

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[3]A *purpose statement* describes the fundamental and unchanging reason the DES exists. It differentiates the DES from other human-resource management systems (and tools).

[4]*Desired outcomes* explicitly describe the intended results of operating the system to achieve its stated purpose—the results that matter to DES customers.

A Basis for Assessing DES Performance

To assess any system's performance, it is first necessary to understand the system's fundamental purpose and its desired outcomes. The system's stated purpose is the foundation for designing, redesigning, organizing, and monitoring every aspect of the system.

We found that no shared statement of purpose for the DoD DES existed; therefore, we constructed a DES purpose statement and a set of desired system outcomes in order to develop our recommendations. We determined that the DES exists to evaluate service members with potentially unfitting conditions[5] in a fair, consistent, efficient, and timely manner and, likewise, to remove those unable to fulfill the duties of their office, grade, rank, or rating, and determine a disability rating percentage for those removed.

We likewise constructed the following set of desired system outcomes:

1. Service members having a similar condition and similar office, grade, rank, or rating receive similar fitness decisions within the military department.
2. Service members found unfit receive similar disability ratings for similar conditions across and within the military departments.
3. Service members freely and appropriately exercise their rights to administrative due process.
4. Service members return to duty, or separate or retire for disability, in a timely manner.
5. Primary participants perform their duties as efficiently as possible so that, collectively, they return service members to duty, or separate or retire them for disability, in a fair, consistent, and timely manner.

Because a common, shared purpose and set of desired outcomes do not currently exist, reaching consensus on these constructs is an important first step in the development of interventions to improve the performance of the DES. Therefore, we recommend that the Assistant Secretary of Defense for Force Management Policy (ASD/FMP) develop a statement of purpose and desired outcomes for the DES to serve as the basis for the DoD DES training program.

Issues of Variability in DES Policy Application and Recommended Interventions

We identified 43 issues—regarding variability in policy application across or within the military departments or problems identified by primary participants—that effect the performance of the DES. The issues-based, bottom-up analysis suggested the

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[5] *Unfitting condition* is a term commonly used in DES policy. Although not explicitly defined in DoD or U.S. statutory documents, the term could be said to refer to "a medical condition resulting from disease or injury that makes a service member unfit to perform the duties of the member's office, grade, rank, or rating" (DoD Directive 1332.18, 1996, p. 2; DoD Directive 6130.3, 1994, p. 1).

following ten categories of broad-based interventions consisting of specific actions for resolving the various issues we identified. We recommend that the DES leadership adopt and act upon these interventions in the context of a near-term plan, as detailed in Chapter 4:

- Assistant Secretary of Defense Decisions
- Policy Guidance
- Organizational Change
- Personnel Policy
- Personnel Management
- Training
- Information Source Development
- Management Information System Deployment
- Process
- Incentives.

Because the recommended interventions are based on reported or observed instances of policy application—information that is not necessarily complete, objective, or empirically based—we expect that the interventions are not as finely tuned as they otherwise might be.

DES Training Analysis and Recommended Changes in Training to Improve System Performance

For the third research task in this study, we present a comprehensive training needs analysis and training recommendations to improve DES performance.

We identified 12 primary participant populations who require specific bodies of knowledge and skills to execute disability policy throughout the military departments. We examined various aspects of the target training population, such as characteristics, turnover, geographic dispersion, subject-matter expertise and variation in levels of required disability evaluation expertise, and computer literacy.

Given the existing job designs for the primary participant populations, we translated the DES purpose and desired outcome statements that we constructed into statements of general competencies for 10 of the 12 primary participant populations. Those primary participant populations, and their respective competencies, are as follows:

Physicians Who Write Narrative Summaries

- are able to determine the appropriate diagnosis
- are able to determine if a service member's condition calls into question his or her ability to meet medical retention standards

- are able to synthesize a service member's medical evidence from all appropriate consultations into a single narrative summary that contains sufficient information in the appropriate format for a PEB to adjudicate the case.

PEBLOs and Disability Evaluation Counselors

- are able to advise service members on the DES process; their rights, benefits, and entitlements; and what to expect as the service member's medical board progresses through the DES
- are able to gather and process patient information to assemble medical boards (case files) that contain sufficient information in the appropriate format for a PEB to adjudicate the case.

Patient Administrators

- are able to assist Medical Evaluation Boards and PEBLOs in gathering and processing patient information to assemble medical boards that contain sufficient information in the appropriate format for a PEB to adjudicate the case.

Medical Evaluation Board Members

- are able to determine whether the medical board includes appropriate specialty consultations with sufficient information
- are able to determine the duty limitations associated with the diagnosis
- are able to determine whether the service member meets the military department's medical retention standards for continued military duty.

Medical Evaluation Board Approving Authorities

- are able to identify complete and accurate medical boards.

PEB Administrative Action Officers

- are able to ensure that contents of medical boards received by the PEB are complete and accurate for adjudication
- are able to obtain missing information, monitor and move medical boards through the system, and exchange information with PEBLOs.

Physical Evaluation Board Members

- are able to apply disciplined military department fitness standards in a uniform manner
- are able to apply other rules uniformly such that members having similar conditions and a similar office, grade, rank, or rating receive similar disability ratings across and within the military departments
- are able to document the substantial evidence that supports all PEB decisions.

Physical Evaluation Board Approving Authorities

- are able to identify consistent application of military department fitness standards such that members having similar conditions and similar office, grade, rank, or rating receive similar fitness decisions within the military department.
- are able to identify consistent application of other rules such that members having similar conditions receive similar disability ratings across and within the military departments
- are able to identify sufficient documentation of the substantial evidence that supports all PEB decisions.

Post-PEB Appellate Review Board Members

- are able to apply disciplined military department fitness standards in a uniform manner
- are able to apply other rules uniformly such that members having a similar condition receive similar disability ratings across and within the military departments
- are able to document the substantial evidence that supports all decisions.

Unit Commanders

- are able to provide written evidence with sufficient detail for PEB consideration that documents their judgment of how a service member's medical condition impacts the member's ability to perform the duties of his or her office, grade, rank, or rating, and specifically how the condition impacts his or her ability to deploy, and whether there are any pending adverse actions against the service member.

The desired system outcomes not only shape the performance competencies for individuals assigned to the DES, they suggest specific knowledge necessary for physicians who refer service members, unit commanders (both active and Reserve) who interact with the DES, and attorneys who advise and represent members. The desired outcomes point to a DoD training emphasis on DES topics and skills in applying knowledge of those topics across the military departments. Likewise, the OSD's focus on consistent policy application suggests that DES topics and the associated skills required to apply knowledge of those topic areas are the most relevant aspects of a DoD training intervention.

As a result, we compiled a comprehensive list of DES training topics from policy documents and military departments' current training syllabi. We associated each suggested topic with the primary participant populations who require knowledge of that topic to produce the desired on-the-job results, recognizing that different populations may apply the same knowledge differently in their respective jobs.

The proposed competencies, together with the analysis of required primary participant population knowledge of specific DES topics to achieve desired on-the-job re-

sults, indicates that the primary participant populations require different levels of knowledge for many of the same DES topics. We sorted the primary participant populations that require essentially the same level of knowledge of the same set of DES topics into five population clusters, as shown in Table S.1.

Further analysis suggested designing the training content—the DES topics for instruction—as five distinct training packages, one per population cluster.

Other considerations in addition to the system's stated purpose, desired outcomes, competencies, and content affect training design. To inform the format and timing of recommended training, we assessed the following considerations: DES-specific knowledge often needed immediately upon assignment; frequency of use of DES topics within the primary participant populations' bodies of knowledge; assignment practices that cause high turnover rates among some primary participant populations; and military departments' DES Web sites.

We observed a common cultural trait across all the military departments—a high commitment to excellence in training, regardless of the training method. Numerous studies in the training literature report "no significant difference" in learning results between self-directed computer-based distance training and traditional classroom training. We compared current military department training practices with the proposed training packages (developed and monitored by the OSD) and analyzed the advantages and disadvantages of designing the DES training program as a self-directed, computer-based distance-training program or as a classroom-training program. Based on our analysis, we recommend that the Office of the ASD/FMP develop and monitor knowledge-based training in which the content focuses on the suggested list of DES topics that collectively constitute a specific body of knowledge for each primary participant population cluster. We further recommend delivering this knowledge-based training through a Web site devoted to disability evaluation training, which is made accessible to all primary participants.

Table S.1

Primary Participant Population Clusters

Population Cluster 1	PEBLOs and disability evaluation counselors Patient administrators PEB administrative action officers
Population Cluster 2	Physicians who write narrative summaries Medical Evaluation Board members Medical Evaluation Board approving authorities
Population Cluster 3	PEB members PEB approving authorities[a] Appellate Review Board members Attorneys who represent and advise service members
Population Cluster 4	Active component unit commanders
Population Cluster 5	Reserve component commanders

[a]These authorities are the Deputy Commander, Army Physical Disability Agency; President, Physical Evaluation Board (Department of the Navy); and Chief, Air Force Physical Disability Division.

This self-directed computer-based distance training is a basic course in disability evaluation. See Table 5.2 in Chapter 5, which organizes a comprehensive list of DES topics into five distance-training packages, each designed to meet the training needs of a particular cluster of primary participant populations. The table further organizes the topics roughly in descending order of common training needs across population clusters, starting with those topics that all population clusters require knowledge of, and ending with those topics required by only one cluster.

All five population clusters require knowledge of many of the same DES topics, although different population clusters need to know how to apply some topics in different ways to achieve their specific, desired on-the-job results. Although the different training packages contain many of the same DES topics, the learning objectives, content presentation, and criterion referencing[6] should match the specific job application needs of each target population cluster (and some learning objectives, content presentation, and criterion referencing will be the same for different population clusters).

We assumed that the OSD develops a Web site devoted to disability evaluation training and establishes the recommended self-directed, computer-based distance-training packages. We further assumed the training packages "teach" the DES bodies of knowledge to the degree intended. We then asked the following question: Do primary participants require additional training to apply policy consistently across and within military departments to produce the desired on-the-job results?

To answer this question, we reexamined the proposed primary participant competencies. The competency statements suggest that PEB members, PEB approving authorities, and post-PEB appellate review board members across military departments, in particular, stand to benefit from collaboration with peers on how to uniformly apply the rules, procedures, and other considerations in determining fitness, assigning the VASRD or analogous codes, and assigning disability ratings.

Likewise, Medical Evaluation Board members and approving authorities across military departments stand to benefit from collaboration with peers in how to apply disciplined medical retention standards uniformly, such that members having a similar condition and similar office, grade, rank, or rating receive similar medical retention decisions. Attorneys who advise and represent members are also likely to benefit from collaboration with Medical Evaluation Board members and approving authorities, PEB members and approving authorities, and appellate review board members across military departments during classroom training.

We recommend supplementing the DoD self-directed computer-based distance-training packages with DoD traditional classroom training for PEB members and approving authorities, post-PEB appellate review board members, and Medical Evaluation Board members and approving authorities across the military depart-

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[6] *Criterion referencing* refers to the method of testing that is most often used in self-directed computer-based distance training. The test questions are written directly from the stated learning objectives and can be answered directly from the material presented. In other words, criterion-referenced tests contain no hidden meanings or trick questions.

ments. The classroom training focuses on applying a particular set of DES topics to develop the skills necessary to evaluate and adjudicate cases and apply disability policy consistently across and within the military departments. The classroom training is designed explicitly to supplement the self-directed computer-based distance training. As such, completing the appropriate distance-training package is a prerequisite for enrolling in classroom training, evidenced perhaps by a certificate of self-certified mastery of the required knowledge and skills. Learning objectives, content, and student learning evaluation differ from the distance-training packages in that they focus on *applying* a particular set of the DES topics learned in the distance-training packages to a variety of real-life cases.

The DES topics shown in Table 5.3 in Chapter 5 form the basis for classroom-training content. That set of DES topics enables students to practice applying the numerous standards, rules, procedures, and other considerations to a wide variety of case studies in a controlled classroom environment in which students collaborate on making decisions that result in consistent dispositions.

Both the self-directed computer-based distance-training packages and the classroom-training package rely on experienced and credible subject-matter experts who are able to develop and deliver high-quality training that produces the desired on-the-job results from the trained populations. These subject-matter experts serve as adjunct faculty who are delegated authority by the OSD to develop and deliver the DoD disability evaluation training.

The self-directed computer-based distance-training packages and the classroom-training package are based on the system purpose and desired outcomes that informed the primary participant competencies proposed in this report.

Like the suggested statements of DES purpose, desired system outcomes, and primary participant competencies, the training analysis and the resulting training packages are presented as a template, or a starting point, for consideration by the Office of the ASD/FMP, in consultation with the Assistant Secretary of Defense/Health Affairs (ASD/HA)and the Assistant Secretary of Defense/Reserve Affairs (ASD/RA), and representatives of the military departments' PEBs and Office of the Surgeons General.

We derived the suggested DES purpose statement and set of DES desired outcomes from DoD and military department documents and from interviews with primary participants. As a result, they should be generally acceptable to decisionmakers in the OSD and military departments; however, we did not attempt to secure agreement from those decisionmakers. Rather, we believe it is essential for the ASD/FMP, in consultation with the ASD/RA and ASD/HA, to decide on a stated DES purpose and set of desired outcomes, using our proposed framework as a starting point. The objective of the ASDs' deliberations is a common framework for developing a sense of ownership of the DES purpose and desired outcomes—the purpose and desired outcomes inform all other decisions and interventions.

Whatever statement of DES purpose and desired system outcomes, and statements of primary participant competencies, are decided upon should form the basis for

conducting a comprehensive training needs assessment which should, in turn, inform development of training packages to enable the primary participants to produce the desired on-the-job results.

If a later assessment of training effectiveness demonstrates that these training packages do not enable the primary participant populations to produce the desired on-the-job results, the OSD should modify the training packages so that they perform as intended.

We estimate that this training program (the combined self-directed computer-based distance-training packages and the classroom-training package) will cost approximately $12.8 million for a five-year training time frame (the majority of this cost is the opportunity cost for course participation). But, the DoD can accrue an estimated $15.2 million in quantifiable benefits from this program in addition to a variety of nonquantifiable benefits.

A Method for Continuously Monitoring DES Performance

To evaluate a system and improve its performance, it is necessary to have a systematic method for tracking how well the system is functioning. We developed a number of performance measures (and metrics that support those measures) that can be used to monitor how well the DES meets external customer expectations, which we defined in terms of the purpose and outcomes of the DES. The DES exists to serve two categories of external customers: service members and individual military services. For service members, expectations center on similar dispositions (among service members in similar circumstances) and due process. For the military services, expectations center on expeditious processing and efficient operations.

The performance measures we developed encompass direct customer perceptions of how well the DES meets their expectations and indirect, but more objective and quantitative, measures of performance. The indirect measures include outcome, output, and input measures that are linked in a framework that identifies the relationship among the measures and how they affect overall system performance. *Outcome measures* include case variability, number of appeals, time to replace an unfit service member, and total system cost. *Output measures* include percentage of primary participants certified, productivity, cost per case, average processing time, number of reworks, and time to promulgate policy change. The sole *input measure* is total resources.

We recommend that the OSD develop and maintain a comprehensive management information system capable of monitoring relevant performance measures that enable leaders to assess, analyze, and take action to continuously improve the performance of the DES. We further recommend that the OSD summarize the information gleaned from the data, which are gathered and analyzed, and share that information with DES primary participants so that they may also act on it to continuously improve DES performance.

ACKNOWLEDGMENTS

This project relied heavily on the expert knowledge and experience of myriad primary participants in the DoD Disability Evaluation System across the military departments. The three departments (Army, Navy, and Air Force) generously allowed us to occupy scarce seats in all of their training events during the course of our study, which expanded our access to a wide variety of primary participants. We are grateful to every person who took the time to answer our questions and share information with us.

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We appreciate the assistance of the representatives from the Office of the Surgeons General in each military department—Ms. Tina Wortzel, Department of the Army; Lieutenant Commander Robert A. Rahal, Bureau of Medicine and Surgery, Department of the Navy, and Colonel Arleen Saenger, Department of the Air Force. We also thank Colonel Michael Montgomery, Office of the Assistant Secretary of Defense/Health Affairs for his insights. These individuals provided key information regarding the medical phase of the system.

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We thank the members of the Formal and Informal Physical Evaluation Boards, members of the legal community, members of the Disability Advisory Council, and the numerous Physical Evaluation Board Liaison Officers and Patient Administrators who openly and willingly shared their experiences, thoughts, and knowledge with us.

Finally, we thank our editor, Nancy DelFavero, for persistently applying her excellent editing skills while accommodating our concerns, and for asking tough, penetrating questions that catalyzed us to communicate our message more clearly.

The details of the Disability Evaluation System are often complex. Any errors or misrepresentations within this report are our own.

ACRONYMS

4-T	Temporary 4 profile
AFPB	Air Force Personnel Board
ASD	Assistant Secretary of Defense
ASD/FMP	Assistant Secretary of Defense/Force Management Policy
ASD/HA	Assistant Secretary of Defense/Health Affairs
ASD/RA	Assistant Secretary of Defense/Reserve Affairs
CCEP	Comprehensive Clinical Evaluation Protocol
CD-ROM	Compact disk—read-only memory
CIM	Corporate Information Management
CONUS	Continental United States
DES	Disability Evaluation System
DoD	Department of Defense
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
EPTS	Existed Prior to Service
FPEB	Formal Physical Evaluation Board
FY	Fiscal year
GAO	General Accounting Office
HIV	Human Immunodeficiency Virus
IG	Inspector General
IPEB	Informal Physical Evaluation Board
LOD	Line of duty

LODD	Line of Duty Determination
MMRB	Military Occupational Specialty Medical Retention Board (Army)
MTF	Military treatment facility
NDRI	National Defense Research Institute
NPT	Neuropsychological Testing
NPV	Net Present Value
OASD/FMP	Office of the Assistant Secretary of Defense/Force Management Policy
OCONUS	Outside the Continental United States
OSD	Office of the Secretary of Defense
PDAB	Physical Disability Appeals Board
PDTTAC	Per Diem Travel and Transportation Allowance Committee
PEB	Physical Evaluation Board
PEBLO	Physical Evaluation Board Liaison Officer
SAFPC	Secretary of the Air Force Personnel Council
SECNAVINST	Secretary of the Navy Instruction
SWATO	Southwest Asia theater of operations
TAP	Transition Assistance Program (Navy)
TDRL	Temporary Disability Retirement List
USAAA	U.S. Army Audit Agency
U.S.C.	U.S. Code
USUHS	Uniformed Services University of the Health Sciences
VA	Department of Veterans Affairs
VASRD	Veterans Administration Schedule for Rating Disabilities

Chapter One

INTRODUCTION

In accordance with Chapter 61 of Title 10, U.S. Code (U.S.C.), Department of Defense (DoD) policy established the Disability Evaluation System (DES) as the mechanism for implementing retirement or separation of a military member due to physical disability. The system consists of four elements: medical evaluation; physical disability evaluation, to include appellate review; counseling; and final disposition.[1]

A service member can potentially experience the system in four progressive phases:

1. A medical evaluation of a potentially disabling condition
2. A physical disability evaluation and an opportunity to appeal findings and recommendations before a formal hearing
3. Two or three higher-level appellate reviews
4. Final disposition (return to duty, separation, or retirement).

The service member receives counseling as needed throughout the process, most intensively during the first two phases.

DoD policy, in accordance with Title 10, U.S.C., requires consistent and equitable application of standards for all determinations related to physical disability evaluation of active component and Ready Reserve service members (DoD Instruction 1332.38, 1996, Sec. 4.3). DoD policy also requires the Secretaries of the military departments to manage the military department-specific DES to ensure uniform interpretation of disability policies and procedures (DoD Instruction 1332.38, 1996, Sec. 5.5.2) and uniform application of the governing laws and DoD policy (DoD Directive 1332.18, 1996, Sec. 4.4.3).

The Principal Deputy Assistant Secretary of Defense (ASD) for Force Management Policy (FMP) asked RAND's National Defense Research Institute to identify and recommend changes to the training provided to the primary participants of the DES to ensure the consistent application of disability policy, across and within the military services: the Army; the Navy, including the Coast Guard when it is operating as a

[1]Although final disposition is an element of the DES, it is carried out by the personnel functions of the military departments, largely in the context of policies unrelated to the DES. Consequently, this report focuses on medical evaluation, physical disability evaluation, and counseling.

military service in the Navy; the Marine Corps; and the Air Force. For the purposes of this report, primary participants in the DES include

- physicians who refer service members to Medical Evaluation Boards, generally known as referring physicians
- physicians who convene Medical Evaluation Boards
- Medical Evaluation Board approving authorities
- Physical Evaluation Board Liaison Officers (PEBLOs)[2]
- patient administrators who support Medical Evaluation Boards and/or PEBLOs
- Physical Evaluation Board (PEB) administrative action officers
- PEB members
- PEB approving authorities[3]
- appellate review board members
- active component unit commanders
- Reserve unit commanders
- attorneys who represent and advise service members.

This report communicates to the Principal Deputy ASD/FMP our assessment and recommended changes to the training provided to primary participants of the DES to ensure consistent application of disability policy, across and within the military services. Our recommendations are based on research conducted between January 1999 and January 2000.

QUESTIONS OF INTEREST REGARDING THE DISABILITY EVALUATION SYSTEM

During early meetings with the DES project sponsor and later meetings with the DES primary participants, the following salient questions were raised.

- What does consistent disability policy application "look like" across and within the military departments?
- What are the desired outcomes or results of consistent policy application across and within the military departments?
- How is consistent disability policy application measured across and within the military departments, given their different missions and requirements?

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[2]In the Department of the Navy, PEBLOs are also known as Disability Evaluation Counselors.

[3]These authorities include the Deputy Commander, Army Physical Disability Agency; President, Physical Evaluation Board (Department of the Navy); and Chief, Air Force Physical Disability Division.

- What are the important causes or sources of variability in the application of disability policy today?
- How much variability is desirable and/or acceptable in the application of disability policy across and within the military departments, given their different missions and requirements?
- What are the most effective means for reducing undesirable and/or unacceptable levels of variability?

Unwarranted variability is the manifestation of a problem—that the system is failing to accomplish its purpose and desired outcomes. Consistent application of disability policy is but one means of addressing this problem. A more robust solution to the problem requires a broader perspective. Underlying the desire to reduce variability is the more fundamental objective of enhancing the ability of the DES to accomplish its purpose and desired outcomes. As a result, the central question of interest now is: How can training and other interventions to improve system performance enable the DES to achieve its desired ends?

RESEARCH APPROACH

In the context of the question, how can training and other interventions enable the DES to achieve its desired outcomes, our specific research tasks focused on improving the performance of the DES. Those tasks include the following:

- Describing a basis for assessing the performance of the DES
- Identifying major issues affecting the current performance of the DES and recommending interventions to resolve those issues
- More specifically, assessing existing training programs in terms of their effect on performance of the DES, and proposing and evaluating recommended changes in content, delivery method, and timing of the training to improve performance
- Developing a process for monitoring the performance of the DES and training effectiveness over time.

We reviewed the governing U.S. statutes, DoD disability policy documents, and the military departments' disability policy documents. We interviewed numerous diverse primary participants of the DES. In addition, throughout 1999, we observed the military departments' major disability evaluation training events—including the annual Navy Physical Evaluation Board Liaison Officer Conference, the twice-yearly Air Force Physical Evaluation Board Liaison Officer Training, the annual Army Worldwide Physical Evaluation Board Liaison Officer Conference, and the annual Army Adjudicators' Course—all of which were provided with PEB resources from the personnel community. We also applied core concepts from the performance measurement, training, and strategic-management literature.

Because no commonly shared statement of system purpose or desired DES outcomes exist across the military departments, except for a narrow focus on timeliness per-

formance standards, we employed two approaches to study the system. First, we employed a bottom-up, issues-driven approach in which we adapted a Goal Fabric Model, described in Chapter 4 of this report, for linking current issues to desired results and actions, objectives, and goals. This approach resulted in numerous recommendations, which we then grouped into ten intervention categories. Later, we employed a top-down, purpose-driven approach in which we formulated a statement of purpose and a set of desired outcomes for the DES. This approach resulted in two major categories of recommendations: changes to training and deployment of a management information system.

ORGANIZATION OF THIS REPORT

This chapter introduced readers to the DES, the primary questions addressed in our research, and our study methodology.

Chapter 2 presents some background on this study. That chapter describes organizational responsibility for training in the DES and highlights findings and recommendations from earlier reports that establish the context for this project.

Chapter 3 articulates a purpose statement and a set of desired outcomes for the DES and suggests using these constructs as the basis for assessing system performance. (The system purpose statement serves as the touchstone for recommendations presented in Chapters 5 and 6). Chapter 3 also identifies the DES external customers and describes the organizational context in which the DES operates. That chapter describes the system operating framework *common* to all the military departments as well as numerous cases of variability.

Chapter 4 describes the issues identified by the primary participants in the course of our issues-driven approach. That chapter presents our analysis of how those issues translate into desired results, actions, objectives, and goals for achieving more consistent application of disability policy. Chapter 4 also presents numerous recommendations for specific interventions, grouped into ten categories; the interventions in two of these categories—training and development of a management information system—are particularly significant and are developed further in Chapters 5 and 6.

Chapter 5 presents an extensive training needs analysis together with an analysis of other considerations in training design. It concludes with a detailed discussion of recommendations for a training intervention program.

Chapter 6 describes the structure of a management information system for monitoring performance of the DES (at the DoD, military department, and military treatment facility [MTF] levels), which is necessary to assess training effectiveness.

Chapter 7 presents a cost-benefit analysis of the training intervention recommended in Chapter 5.

Chapter 8 offers our conclusions and observations. In particular, we discuss the value of purposefully establishing a system performance perspective with which to address other complex issues beyond the scope of this report.

Chapter Two

BACKGROUND ON THE DISABILITY EVALUATION SYSTEM

Department of Defense policy, as reflected in DoD Directive 1332.18 and DoD Instruction 1332.38, asserts that the Disability Evaluation System is established to conduct physical disability evaluation in a consistent and timely manner. In light of this stated policy, this chapter presents background information on training in the DES and recommendations from previous studies of the system.

TRAINING AS A CENTRAL FOCUS OF THIS STUDY

DoD Directive 1332.18 (1996) emphasizes the role of training in achieving the DES goal of conducting physical disability evaluation in a consistent and timely manner. It directs the Assistant Secretary of Defense for Force Management Policy (ASD/FMP), in coordination with the Assistant Secretary of Defense for Health Affairs (ASD/HA) and the Assistant Secretary of Defense for Reserve Affairs (ASD/RA), to develop and maintain a program of instruction for the DES.

DoD Directive 1332.18 also directs the ASD/HA to develop and maintain a program of instruction for use by MTFs on the preparation of medical evaluation boards[1] for physical disability cases, and a program of instruction for use by PEB adjudicators and appellate review authorities on the medical aspects of physical disability adjudication, to include the application of the Veterans Administration Schedule for Rating Disabilities (VASRD). Appendix A of this report describes the organizational responsibilities for the DES within the Office of the Under Secretary of Defense (Personnel and Readiness) and the military departments.

In sponsoring this research, the Principal Deputy ASD/FMP also emphasized the role of training, one of many management tools for developing and sustaining the knowledge, skills, and behaviors needed to produce the desired results of the DES in a consistent manner. In addition, by uniformly interpreting and communicating disability policy, training can play a key role in conveying a "consistent policy

[1]To avoid confusion with the use of the acronym MEB—which is commonly used to indicate the group of physicians who convene as a board, the narrative summary, and the complete disability case file—we spell out "Medical Evaluation Board" when referring to the group of physicians who convene as a board (including those who pass records among themselves without actually convening a board). We refer to the narrative summary as the "narrative summary" and the disability case file as the "medical board."

application" message. Consistent policy application is more likely to occur when each primary participant is able to apply the body of knowledge and skills learned in training that are targeted to produce the desired results on a specific job.[2]

The focus on training within the DES is not new; it dates back at least to the beginning of the 1990s. A 1992 DoD Inspector General Audit Report recommended a joint training program for disability evaluators that includes, as a minimum, line-of-duty (LOD) criteria, presumption-of-fitness determinations, prior-to-service criteria, application of the VASRD, and preparation of documentation to support PEB decisions. The ASD/HA formally replied on February 13, 1992, that the Office of the ASD/HA would develop a joint training program for newly assigned members of the boards composing the DoD DES to promote consistency in the application of the disability separation laws.[3] As of this writing, however, the responsibilities outlined in DoD Directive 1332.18 notwithstanding, no such joint program has been developed.

Even in the absence of training standards prescribed by the Office of the Secretary of Defense (OSD) or a program of instruction, the military departments conduct training for primary participants. The Army Physical Disability Agency develops and delivers a training program tailored to the needs of Army adjudicators and invites a limited number of adjudicators from the other military departments to attend. Other Army primary participants aggressively and continuously seek to attend the course as reflected in data from the December 1999 Army Adjudicators' Training Course, which showed that only two of the 68 attendees represented the target training population of practicing adjudicators.

The Army Physical Disability Agency and the Air Force and Department of the Navy Physical Evaluation Boards (all three groups reside within the personnel community) each organize and conduct conferences or seminars designed primarily for their own PEBLOs. Because demand for disability training is high, other primary participants of the DES also attend on a space-available basis, including a limited number of participants from the other military departments.

The following section establishes the context within which this study took place, starting with the findings of the 1992 DoD Inspector General Audit Report.

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[2]As noted in Chapter 1, this study originally focused on training interventions to achieve more-consistent application of disability policy across and within military departments. As the study progressed, it became clear that consistent policy application is simply one means of improving overall system performance, and it alone is not sufficient for developing comprehensive training recommendations.

[3]The full text of the ASD/HA response to the report of the Inspector General is as follows: "By 1 March 1992, the ASD(HA) will forward a memorandum to the Secretaries of the Military Departments and the President, Uniformed Services University of the Health Sciences (USUHS) requesting the appointment of 2 members from each Service and from USUHS to establish a working group whose responsibility it will be to identify the subject matter for the joint training program. The working group will be established by 1 April 1992. The Center for Interactive Media at the USUHS will develop an interactive video from the subject matter input from the working group. Completion of the training program will require an estimated 12 months. Estimated date of completion of the joint training program is 1 June 1993."

FINDINGS AND RECOMMENDATIONS FROM PREVIOUS STUDIES OF THE DISABILITY EVALUATION SYSTEM

This section summarizes findings and recommendations from related recent reports that made recommendations similar to the ones in this report. The first two summaries in this section discuss the performance of the DoD Disability Evaluation System. The next two summaries discuss the performance of the Army Physical Disability Agency, and the final summary in this section discusses the performance of the veterans disability compensation programs in the Department of Veterans Affairs (VA).

Medical Disability Discharge Procedures (June 8, 1992)

The DoD Inspector General audited the military departments' medical disability discharge procedures (Office of the Inspector General, 1992) to determine whether service members identified as medically disabled were expeditiously discharged from the military departments, and to assess the effectiveness of the discharge process and related internal controls. The Office of the Inspector General determined that the DoD disability system was neither efficient nor economical. Disability cases were not processed promptly, and service members were incorrectly rated for their disabilities. The Office of the Inspector General found that OSD guidance was inadequate and the DoD lacked adequate oversight of the disability process.

- In particular, the report noted among other findings that the DoD Directive 1332.18—originally titled *Separation from Military Service by Reason of Physical Disability,* February 25, 1986—did not contain standard time frames for processing medical boards and evaluation boards and did not provide adequate criteria for rating disabilities and prior-to-service conditions. It also found that military personnel were assigned to serve on PEBs without any training on how to evaluate disability cases.
- High turnover among board members plus the lack of formal training contributed to rating deficiencies.
- Frequently, medical boards did not contain an LOD determination or the statement was inadequate.
- A system did not exist to collect data from the PEBs on how quickly cases were processed or the number of cases for each medical condition.

The DoD Directive 1332.18 was revised and re-titled as *Separation or Retirement for Physical Disability,* and was reissued on November 4, 1996. The supplemental new DoD Instruction 1332.38, *Physical Disability Evaluation,* November 14, 1996, specifies standard processing times, as follows, and includes criteria for rating disabilities and prior-to-service conditions:

> Not more than 30 days from the date the physician dictates the Medical Evaluation Board Report to the date the Physical Evaluation Board receives the medical board.

> Not more than 90 calendar days to conduct a Medical Evaluation Board or physical examination in cases of Reserve component members referred solely for a fitness determination of a non-duty-related condition.
>
> Not more than 40 days from date the Physical Evaluation Board receives the medical board or physical examination report to the date of the determination of the final reviewing authority as prescribed by the Secretary of the military department.

Based on our interviews with the primary participants and our other observations, individuals still to this day are assigned to serve on PEBs usually without the benefit of standardized training on how to evaluate disability cases.

High turnover among PEB members and the PEB approving authorities still exists and formal training is still offered only infrequently. Primary participants from all of the military departments reported that now, as in 1992, medical boards frequently do not contain an LOD determination or the statement is inadequate. By January 1992, the Department of the Navy Disability Evaluation System received funding for a Management Information System (Office of the Assistant Secretary of Defense, Health Affairs, 1992), the genesis of the current Joint Disability Evaluation Tracking System.

Preliminary Functional Economic Analysis (November 1993)

To address the findings of the DoD Inspector General Audit Report (1992), the Office of the ASD/HA convened the Joint Service Disability Working Group to analyze and recommend improvements for the disability evaluation process using the Corporate Information Management (CIM) methodology[4] (Joint Service Disability Working Group and Systems Research and Applications Corporation, 1993). The work group determined that although the medical and disability investigation functions were similar among the military departments and compliant with the law, the implementation of the disability evaluation process differed among the military departments. Of the differences, the work group reported that only one was justified and should be preserved: the difference in fitness and retention standards among the services due to mission requirements.

The work group noted that the future DES should be performance-based and recommended the following actions to achieve the desired performance-based DES of the future:

- The Office of the Secretary of Defense and military departments should
  - issue specific policy guidance
  - cooperate with the VA
  - employ sound business practices.

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[4]The CIM methodology rigidly focuses on a functional process improvement cycle that includes: defining objectives, strategies, and a baseline; analyzing functional processes; evaluating alternatives; planning for implementation; approving proposed changes; executing new processes and systems; and comparing the results with the first stage in the cycle, defining objectives, and other steps in the process.

- Disability Evaluation System leaders monitor system performance, learn from it, and take action based on the performance measures.

The work group developed two alternatives to produce a uniform process across the military departments and timely fitness and disability determinations:

1. Alternative A recommended basic improvements and actions that would simplify the process, such as
- transfer policymaking to the Office of the Assistant Secretary of Defense (Personnel and Readiness)
- create a Disability Evaluation Council
- develop an automated information system with monitoring and reporting capability
- develop and field education programs.
2. Alternative B, which presupposed Alternative A implementation, included significant functional changes such as eliminating informal reviews not required by law; moving fitness and retention decisions to local (base/post) level; and later moving disability rating decisions to the local level once an automated disability rating "advisor" could be fielded at the local level.

Since the Preliminary Functional Economic Analysis report was published, policymaking has been transferred to the Office of the Under Secretary of Defense (Personnel and Readiness) and the Disability Advisory Council was established. Establishing the Joint Disability Evaluation Tracking System can be seen as an initial effort to create an automated information system capable of both monitoring and reporting.

Disability Payments to Military Personnel (December 1989)

In 1988 to 1989, the U.S. Army Audit Agency (USAAA) conducted an audit of disability payments to military personnel (U.S. Army Audit Agency, 1989). Although the USAAA reported that the PEBs properly and consistently adjudicated cases, it also reported problems with case processing time and the ability of the Army Physical Disability Agency to measure system performance so that managers could identify and correct unnecessary delays. The USAAA estimated that delays in case processing cost the Army about $19.4 million in active duty personnel costs annually.

The USAAA recommended that MTFs properly prepare all reports and forms and expedite processing of medical boards. It specifically recommended that the Army Physical Disability Agency

- coordinate with the Office of the Surgeon General and the Total Army Personnel Command to develop processing time standards to cover all key segments in the DES
- develop a standard system for recording and reporting action dates for each key segment of the DES

- periodically prepare reports based on data in the information system and disseminate the reports to responsible activities.[5]

Follow-up Audit of Disability Payments to Military Personnel (December 1994)

In its follow-up audit of the disability payments to military personnel, the USAAA found that problems still existed in the DES (U.S. Army Audit Agency, 1994). The USAAA reported that the Army Physical Disability Agency needed to improve its oversight of disability case processing, clearly define responsibilities for enforcing requirements of the DES, and improve its management information systems. It specifically recommended that the Army Physical Disability Agency

- update Army Regulation 635-40 (AR, 1990) to clearly delineate time standards for each segment of the disability process and requirements for activities to monitor the timeliness of case processing
- establish quality assurance controls and periodically verify the accuracy of automated information.

To date, Army Regulation 635-40 has not been revised.

The USAAA did note that the Army Physical Disability Agency was taking a number of actions to improve its management of the disability process including participating in a DoD study group to review the disability process with all military departments; conducting, along with the Office of the Surgeon General, an analysis of the Army's disability evaluation system; making arrangements for MTFs to obtain automation equipment; and reviewing its organization structure for more cost-effective business approaches.

The USAAA also reported that processing time was still too high. Although the Army Physical Disability Agency had developed time standards and implemented a measurement system for case processing time, actual case processing times did not decrease. The USAAA noted that the increased number of disability cases due to Operation Desert Shield and Operation Desert Storm may have contributed to timeliness problem.

The USAAA recommended that the Deputy Chief of Staff for Personnel

- coordinate with the Surgeon General to develop a plan to reduce processing time
- require the Army Physical Disability Agency to periodically report case processing time
- monitor case processing performance.

In addition, the USAAA advocated that the Surgeon General

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[5]*Activities*, as used here, is a department term referring to organizations or units.

- require that major medical commands include the timeliness of disability case processing in command personnel reviews and inspections
- monitor processing time
- require doctors to provide reasons for delays
- ensure that administrative staff members possess proper knowledge on disabilities.

The Veterans' Claims Adjudication Commission Report to Congress Pursuant to Public Law 103-446 (December 1996)

Section 402(e)(2) of Public Law 103-446 called for the establishment of the Veterans' Claims Adjudication Commission, which examined the performance of disability compensation programs within the Department of Veterans Affairs. The Commission concluded that, in regard to the adjudicative and appellate process and procedures, "the shortcomings of the existing system are many and varied."

Lack of a clear statement of purpose for veterans' disability compensation is a huge shortcoming that makes it difficult to both determine performance measures and actually measure performance. Although language in Title 38, U.S.C., and language in VA regulations strongly suggest that disability compensation is intended to compensate for lost earning capacity, and numerous congressional committee reports express similar intent, no clear statement of purpose exists in statute.

The report (GPO, 1996) makes numerous recommendations; however, it emphasizes that no single intervention is likely to impact system performance sufficiently to alter "perceptions that the VA system is failing, is not efficient, and/or does not provide appropriate service to veterans." The report laments that credible data and long-term analysis of program trends do not support decisionmaking in the VA. It concludes that, among other things, the Congress and Department of Veterans Affairs require objective and contextual information to inform attempts to redesign or improve the VA disability compensation system. Among the many recommendations specified by the commission, the following relate to this report:

- Congress should amend Title 38, U.S.C., to clearly state the purpose of the veterans' pension program.
- The Secretary of Veterans Affairs should actively support and encourage the efforts of the VA's Chief Information Officer to execute the Chief Information responsibilities and authorities (that is, establish a management information system capable of monitoring performance and establishing long-term trends).
- Routine analysis of operations should be based on a single set of predetermined performance measures.
- To enhance accountability, the Veterans' Benefits Administration and the Board of Veterans' Appeals should incorporate organizational goals and objectives (at the department, administration, and board levels) into individual performance plans.

- The Veterans' Benefits Administration and Board of Veterans' Appeals should integrate timeliness of processing into their Quality Control and Quality Assurance frameworks.

The next chapter of this report suggests a statement of purpose and a set of desired outcomes for the DoD DES. It explains the organizational setting of the DES and describes the common DES operating system across military departments as well as numerous cases of variability.

Chapter Three

DISABILITY EVALUATION SYSTEM OVERVIEW

This chapter describes the DoD Disability Evaluation System from five perspectives: (1) its stated purpose and desired outcomes, (2) its external customers, (3) its organizational setting, (4) the DES operating framework that exists in common across the military departments, and (5) aspects of DES operations that are unique to certain military departments. Examining the DES from these perspectives is important to gaining a thorough understanding of both the system and the recommendations described in this report.

The first section of this chapter discusses the *purpose* of the DES. We give the system's purpose the preeminent position in this chapter because it is central to any effort to improve the operation of the DES. The first section also outlines a set of desired outcomes that explicitly states the intended results of operating the system to achieve its purpose. The second section of this chapter identifies the DES customers and their expectations of the system.

Because the DES exists within an organizational setting, the third section of this chapter describes the elements of the system within that setting, the organizational location of those elements within the military departments, and the relationships and flow of information among the organizations that operate the various elements of the DES and among other organizations inside and outside the military departments.

The final section of this chapter summarizes the common operating framework of the DES across the military departments and aspects of DES operations that are unique to certain military departments, in other words, instances of variability.

PURPOSE STATEMENT AND DESIRED OUTCOMES

A purpose statement describes the fundamental and unchanging reason for the DES's existence. It differentiates the DES from other human resource management systems (and tools) and is the foundation for designing, redesigning, organizing, and monitoring every aspect of the system.

Lacking explicit direction from the Office of the Secretary of Defense (OSD) on the *purpose* of the Disability Evaluation System, the military departments tend to interpret DoD policy language to fill the directional void and operate their systems

accordingly. Their statements of purpose (or "objectives" or "mission statement") include various renditions and combinations of five themes:

1. Maintain a fit force.
2. Provide compensation and benefits.
3. Remove unfit members from active duty.
4. Balance the interests of the government and the service member.
5. Serve both active and Reserve service members implicitly; the Department of the Navy explicitly includes the Reserve components.

The military departments' various DES purpose statements, along with the mission statement set forth by the Joint Service Disability Working Group in 1993, appear in Appendix B.

The system's stated purpose should be the foundation for any major change in the direction, structure, or operation of the DES. After extensive discussions with its primary participants and based on a review of OSD and military department documents, we formulated the following statement of purpose of the Disability Evaluation System:

> The Disability Evaluation System exists to evaluate service members with potentially unfitting conditions[1] in a fair, consistent, efficient, and timely manner and, likewise, to remove those unable to fulfill the duties of their office, grade, rank, or rating, and determine a disability rating percentage for those removed.

This proposed statement of purpose explains why the system exists. And similarly, the desired outcomes explicitly describe the intended results of operating the system to achieve its stated purpose: results that matter to DES customers. As was the case with the lack of a common purpose statement, we found no shared understanding among the military departments or between the OSD and the military departments regarding a set of desired outcomes.[2] As a result, in addition to proposing a purpose statement, we also propose the following set of desired system outcomes, which if met, will lead to achieving that purpose:[3]

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[1]"Unfitting condition" is a term commonly used in DES policy. Although not explicitly defined in DoD or U.S. statutory documents, the term could be said to refer to "a medical condition resulting from disease or injury that makes a service member unfit to perform the duties of the member's office, grade, rank, or rating" (DoD Directive 1332.18, 1996, p. 2; DoD Directive 6130.3, 1994, p. 1).

[2]The OSD relies on time standards for processing medical boards through the Disability Evaluation System to assess system performance. Chapter 6 outlines a comprehensive performance measurement system that relates output measures, such as medical board processing time, to desired outcomes.

[3]We derived the purpose and outcomes from the DoD and military department documents and from interviews with primary participants. As a result, they should be generally acceptable to decisionmakers in the OSD and military departments; however, we did not attempt to secure agreement from those decisionmakers. Rather, we believe it is essential for the ASD/FMP, in consultation with the ASD/RA and ASD/HA, to decide on a stated DES purpose and desired outcomes, using our proposed framework as a starting point. The objective of their deliberations is a common framework to develop a sense of ownership of the DES purpose and desired outcomes—the purpose and desired outcomes inform all other decisions and interventions. This purpose-driven approach is discussed in greater detail in Appendix F.

1. Service members having a similar condition and similar office, grade, rank, or rating receive similar fitness decisions within the military department.
2. Service members found unfit receive similar disability ratings for similar conditions across and within the military departments.
3. Service members freely and appropriately exercise their rights to administrative due process.
4. Service members return to duty, separate, or retire for disability in a timely manner.
5. Primary participants perform their duties as efficiently as possible so that, collectively, they return service members to duty, or separate or retire service members for disability in a fair, consistent, and timely manner.

The two major DES interventions recommended in Chapters 5 and 6 flow from the proposed purpose statement and set of desired outcomes. Because a shared purpose and shared understanding of desired outcomes do not currently exist, reaching consensus on a purpose statement and a set of desired outcomes is an important first step in the development of interventions to improve the performance of the DES. We recommend that the OSD make reaching this consensus a key initial action.

We used the purpose statement and outcomes proposed here to develop the two major recommendations discussed in Chapters 5 and 6, recognizing that some of the specifics will change if the OSD modifies the proposed purpose—the foundation of the DES's existence. However, based on our discussions with the primary participants, we believe that the purpose statement and outcomes we suggest are close to those that will eventually be agreed upon.

EXTERNAL CUSTOMERS

The military departments operate their DESs to benefit two customers: individual service members and individual military services. The system's stated purpose and desired outcomes define customer expectations. As such, service member expectations center on similar dispositions (among service members in similar circumstances) and on due process. Service expectations center on expeditious processing and efficient operations.

For a discussion of measuring system performance in terms of how well it meets external customer expectations, see Chapter 6.

THE ORGANIZATIONAL SETTING

The DES operates to achieve its stated purpose within a larger organizational context. According to DoD policy documents, the DES is composed of four major elements. Significantly, no single organization within the military departments "owns" all of the elements of the system. The DES interfaces with other systems within the military departments. The organizations that constitute the DES exchange operationally critical information with other organizations within the military departments

and with one external organization, the Department of Veterans Affairs. The DES's operation within this context directly affects its performance.

The Elements of the Disability Evaluation System

DoD policy documents identify the four elements that constitute the Disability Evaluation System:

- medical evaluation
- physical disability evaluation, to include appellate review
- counseling
- final disposition.

A service member enters the DES when a medical evaluation calls into question his or her ability to meet medical retention standards to perform military duties.[4] A member who does not meet medical retention standards progresses to a physical disability evaluation.

Primarily while undergoing medical and physical disability evaluations, the service member receives counseling regarding what to expect throughout all phases of the disability evaluation process, the significance and consequences of the determinations that are made, and his or her rights, benefits, and entitlements.

A member who disagrees with the physical disability evaluation findings and recommendations may redress that disagreement through appellate review.

Appropriate personnel authorities accomplish final disposition of the service member's case by issuing orders and instructions to implement the determination of the respective military department's final reviewing authority. The service member exits the DES by returning to duty, separating (with or without compensation), or retiring for disability or length of service. Figure 3.1 illustrates the four elements that constitute the DES. It notes that the counseling element primarily occurs simultaneously with the medical evaluation element and the physical disability evaluation portion of the second element.

The admittedly simple representation of the DES shown in Figure 3.1 belies its underlying complexity. Some of that complexity arises because no single organization owns all the elements of the system.

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[4]This introduction to the four elements of the DES is based on DoD disability policy documents and does not include the variations that exist across the military departments, such as the alternative route into the Army DES through the Military Occupational Specialty Medical Retention Board. The last section of this chapter specifies the operational and structural differences that we identified within the three military departments' DESs in the context of the system framework that is common across the military departments.

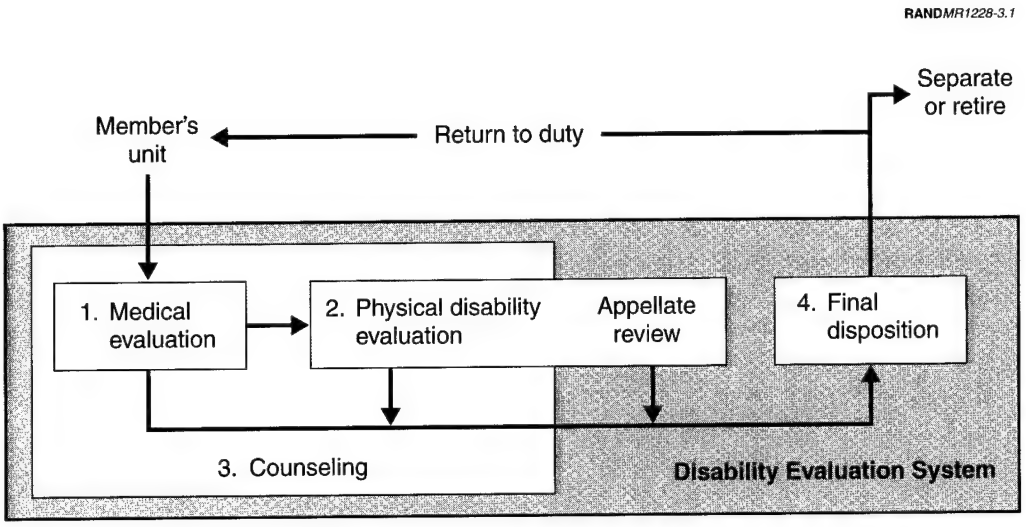

Figure 3.1—Elements of the Disability Evaluation System

Organizational Location

The Disability Evaluation System is but one of the systems supporting the personnel (human resource management) communities of the military departments. The system, ideally, supports the broader goals of the personnel functions of which it is a part, which in turn support broader enterprise goals of the military departments and the DoD. In fact, the "maintain a fit force" theme identified in the various purpose statements of the military departments, as noted earlier in this chapter, highlights the linkage between the DES and the enterprise goals of the military departments and the DoD to maintain a fit force. As one of many management tools to support the enterprise goals, the DES is the specific tool used to evaluate service members with medical conditions that make them potentially unfit to perform their duties, and to remove those service members who are unable to fulfill the duties of their office, grade, rank, or rating.

Two functional areas within the military departments collaborate to operate the DES: the medical community and the personnel community.

The Medical Evaluation Board,[5] which is responsible for the medical evaluation element, is organizationally located at the MTFs. The board is part of the medical community of the military departments.

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[5]To avoid misunderstanding, we avoid using the acronym *MEB*, which is commonly used to mean three different things: the group of physicians who convene as a board, the narrative summary, and also the complete disability case file. Instead, we use the term "Medical Evaluation Board" when referring to the group of physicians that convene as a board (including those who pass records among themselves without actually convening a board), we refer to the narrative summary as the "narrative summary," and we refer to the disability case file as the "medical board."

As later chapters of this report describe, many of the primary participants of the DES view the Physical Evaluation Board, which is responsible for the physical disability evaluation element, as the heart of the system. The PEB is part of the personnel community in all three military departments, although each department positions the PEB within a different part of its overall organizational structure. The Army PEB, for example, belongs to the Army Physical Disability Agency, Office of the Adjutant General, Total Army Personnel Command. The Department of the Navy PEB is a component of the Director, Naval Council of Personnel Boards, Office of the Assistant Secretary of the Navy (Manpower and Reserve Affairs). The Air Force PEB belongs to the Air Force Physical Disability Division, Directorate of Personnel Program Management, Air Force Personnel Center.

In addition, the higher-level appellate review beyond the PEB in the second element of the DES and the final disposition element reside organizationally within the personnel community.

To achieve its purpose, the DES also interfaces with other organizations within the military department: each service member's unit and the Office of the Judge Advocate General. The service member's unit has a direct interest in the operation of the DES because the unit must operate without a replacement for the service member until final disposition of the case, and the service member receives legal advice and representation from an attorney from the Office of the Judge Advocate General.

Figure 3.2 portrays the organizational setting of the DES within the medical community (in particular, MTFs) and the personnel community and its interface with the other military department organizations: the service member's units and the Office of the Judge Advocate General.

The flow of information among these entities is even more abundant than Figure 3.2 suggests. Given the organizational setting illustrated in Figure 3.2, Figure 3.3 portrays the DES as one of many major systems that exchanges information, including one

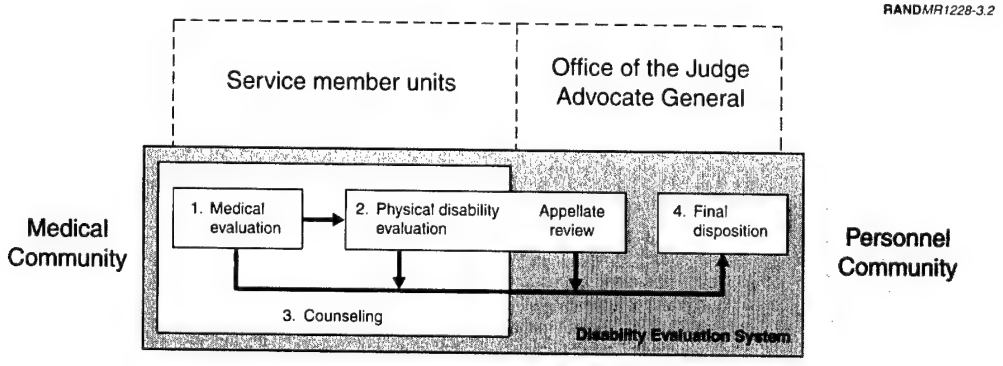

Figure 3.2—Key Disability Evaluation System Organizational Interfaces

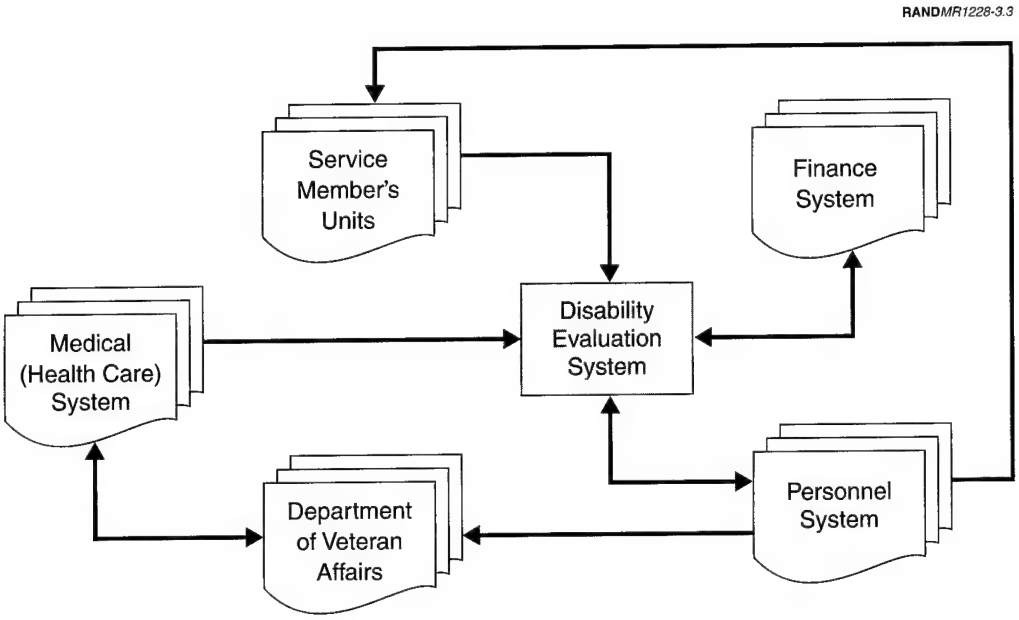

Figure 3.3—Flow of Information Among Major Military Department Systems

system external to the DoD, the Department of Veterans Affairs. For the DES to operate smoothly and efficiently, the military departments must understand, and manage, these interfaces and information streams.

The military departments operate their individual systems based on their interpretations of DoD disability policy. Careful examination revealed essentially identical system frameworks, with numerous operational and structural variations, across the military departments. The following section describes the system framework that is common across the military departments in terms of process, primary participants and their roles, information examined, and range of disposition options in each phase of the process. Within the context of a common system framework, the following section also specifies the operational and structural variations that we identified within the three military departments' DESs.

SYSTEM OPERATING FRAMEWORK ACROSS DEPARTMENTS: OVERVIEW OF THE FOUR DISABILITY EVALUATION PHASES

As noted earlier, DoD disability policy documents set forth policy within a framework that consists of four *elements*: (1) medical evaluation; (2) physical disability evaluation, to include appellate review; (3) counseling; and (4) final disposition by the appropriate personnel authorities.

This section describes the system's operational framework. It reorients the policy focus from "elements" to "phases" through which an individual service member's case may move, introducing a systems perspective of the DES.

A service member who enters the DES can potentially pass through four progressive phases:

1. Medical evaluation and disposition by the Medical Evaluation Board
2. Physical disability evaluation, including the possibility of a formal hearing, and disposition by the PEB
3. Two or three higher levels of appellate review beyond the PEB
4. Final disposition by the appropriate personnel authorities.

Counseling, cited as the third "element" within disability policy documents, is not a separate phase. Counseling aids service members as they progress through the first two phases in particular. Figure 3.4 portrays the four phases of the DES in relation to the four individual DES elements.

When a service member has received maximum benefit from medical treatment for a condition that may prevent the service member from meeting medical retention standards,[6] and the service member fails to improve or recover, he or she may be referred to a Medical Evaluation Board by

- a physician
- the unit commander, through the MTF commander
- the service headquarters or higher command.

Note: Other means of referral to a Medical Evaluation Board exist in two military departments:

- The Army Military Occupational Specialty Medical Retention Board (MMRB), an administrative screening board that evaluates the ability of service members with a "permanent 3" or "permanent 4" medical profile to physically perform in a worldwide field environment in their primary military occupational specialty, may direct referral to a Medical Evaluation Board. When the MMRB refers a service member to a Medical Evaluation Board, the service member must be referred to the PEB, whether or not the member meets medical retention standards.
- The most frequent cause of referral to the Medical Evaluation Board in the Department of the Navy is that the service member used all of the Temporary Limited Duty available and still requires medical treatment. The Chief, Naval Operations; Chief, Marine Corps; Chief, Naval Personnel; and Chief, Bureau of Medicine and Surgery may order an MTF to convene a Medical Evaluation Board for a member (Secretary of the Navy Instruction 1850.4D, 1998, p. 3-2).

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[6]The services employ different medical retention standards, spelled out in U.S. Department of the Army Regulation 40-501 (1995), and U.S. Department of the Army Regulation 40-501, Change 1 (1998); U.S. Secretary of the Navy Instruction 1850.4D (1998); and U.S. Department of the Air Force Instruction 36-3212, (1998).

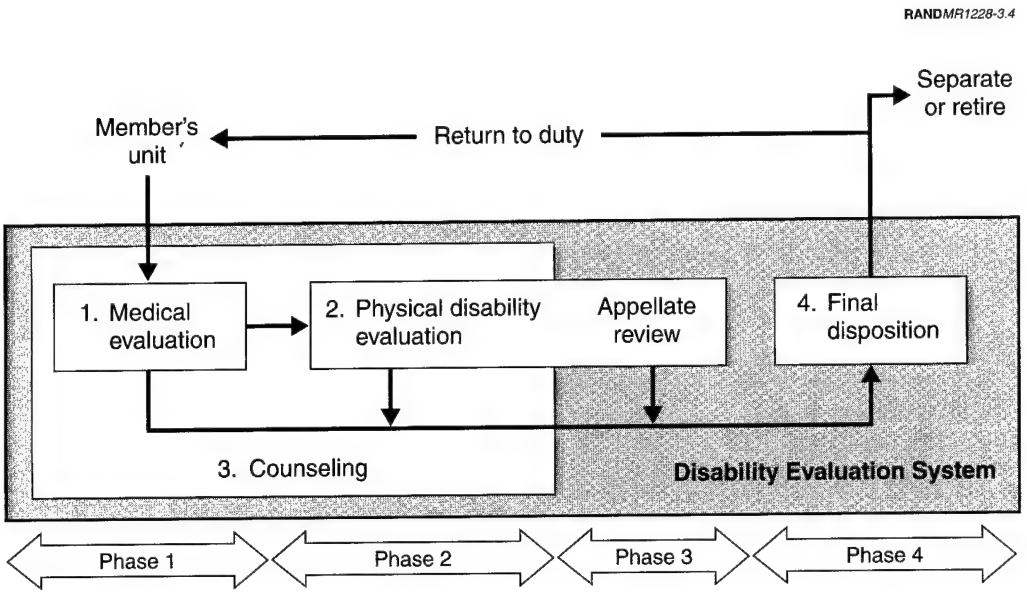

Figure 3.4—Elements and Phases of the Disability Evaluation System

Phase 1. Medical Evaluation and Disposition by the Medical Evaluation Board

A service member's case enters the Disability Evaluation System when the referring physician dictates a narrative summary[7] for a Medical Evaluation Board.[8]

Note the following military department–specific differences:

- Interns may write narrative summaries at the Army MTFs.
- First-year residents generally write the narrative summaries at Department of the Navy MTFs.
- The Departments of the Army and Navy refer service members who have a high probability of *not* returning to duty to Medical Evaluation Boards.
- The Air Force refers service members who have a high probability *of* returning to duty to Medical Evaluation Boards.

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[7]Although practitioners in all the services frequently refer to the narrative summary document as a "medical board," this report uses the term *medical board* exclusively to refer to the complete disability case file including the narrative summary and all other associated addenda. The Army calls the narrative summary a "MEB narrative summary."

[8] An active or Reserve component service member with a prognosis of death within 72 hours and an LOD Determination of Yes (LOD-Yes) enters the Disability Evaluation System any time, day or night, for expeditious disability retirement processing, also known as *imminent death processing*. Based on an investigation of the circumstances surrounding a service member's disabling medical condition under the regulations of the respective military department, an LOD determination is made during the physical disability evaluation phase to establish whether the member's disability was incurred or aggravated while the member was in a duty status, as defined in DoD Instruction 1332.38 (1996).

Factors that lead to a Medical Evaluation Board for active duty service members include the following:

- a condition that may permanently interfere with service and/or require permanent assignment limitations
- mental incompetency in managing personal affairs
- member's refusal of reasonable medical treatment.

Note the following military department–specific differences:

- In the Department of the Army, a service member undergoing treatment for medical conditions may receive a period of convalescent leave during which he or she is still considered a patient of the MTF; the service member must return periodically for evaluation by a physician. A service member who can return to duty with restrictions is given a profile. Profiles are either temporary, to be reevaluated at a given date, or permanent, to remain with a service member for the remainder of his or her career. In some of these cases, a service member's ability to meet retention standards may be questionable, resulting in referral to a Medical Evaluation Board.
- In the Department of the Navy, a service member may receive up to 30 days of "light duty" while undergoing treatment for a medically diagnosed condition. If the member continues to need medical treatment at the end of the 30-day period, he or she may be referred to a Limited Duty Board or Medical Evaluation Board for further evaluation. The member may receive up to 16 months of Temporary Limited Duty (in up to eight-month increments) or spend up to 30 days in Medical Hold pending completion of a Medical Evaluation Board referral to the PEB.
- In the Air Force, the Medical Standards Branch assigns and removes "Code C," an assignment limitation code, to a member's personnel records. The system monitors a service member assigned Code C and generally examines his or her medical condition every one or two years, depending on the condition. The Air Force does not limit the length of time a member may serve with a Code C.

From the perspective of primary participants across the military departments, the date a narrative summary is dictated is generally accepted as the date the service member enters the DES. However, from the perspective of the service member, substantial time may pass between the date the referring physician decides the service member's medical condition calls into question his or her ability to meet medical retention standards and the date the physician actually dictates the narrative summary. During this intervening time, the service member schedules and awaits the appropriate specialty consultations, the results of the various medical tests, and the synthesis of all of his or her pertinent medical evidence into a narrative summary.[9]

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[9]Numerous primary participants expressed concern that progression through this preliminary phase is not generally monitored and many service members get "lost"—that is, delayed—in the system while

The narrative summary initiates the service member's disability case file, which is generally referred to as the "medical board" or the "MEB."

The narrative summary documents the full clinical information for all of the service member's medical conditions and states whether any of them is cause for referral into the DES. The summary includes a medical history, results of appropriate physical examinations, and medical test results. It synthesizes all pertinent medical evidence from all appropriate medical and surgical consultations into one comprehensive document together with diagnosis, treatment, and prognosis. It clearly describes the service member's current physical and/or mental condition in enough detail for the PEB to adjudicate the case. Although all narrative summaries require specific detailed medical data for PEB adjudication,[10] the following categories of cases require information in greater detail and with more specificity than other categories require:

- Orthopedic
- Neurological/Neurosurgical (in particular, backs)
- Ophthalmologic
- Pulmonary
- Cardiological
- Psychiatric
- Migraine headache–related
- Fibromyalgia
- Rheumatology.

DoD Instruction 1332.38 (1996) encourages physicians who prepare medical boards for referral for physical disability evaluation to use the Department of Veterans Administration's *Physician's Guide for Disability Evaluation* to describe the nature and degree of severity of the member's condition.

Each medical board contains numerous additional documents, depending on the particular case and the military department's administrative requirements. All, however, contain the following nonmedical documents: (1) a letter from the service member's commander describing the impact of the service member's medical condition on the member's ability to perform his or her normal military duties and to deploy or mobilize, as applicable; (2) a copy of the LOD determination, when required; (3) pertinent personnel records as required by the member's service to establish his or her military history; and (4) an official document identifying the next of kin, court appointed guardian, or trustee when a service member is determined

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waiting for all the required actions before the physician dictates the narrative summary. Some MTFs reportedly manage this otherwise unmonitored period of time to their advantage by requiring physicians to wait to dictate the narrative summary until the PEBLO assembles all of the medical and nonmedical documents that constitute a medical board. This practice contributes to decreased Medical Evaluation Board processing time, which is reported to the OSD.

[10]Department of Defense Instruction 1332.39 (1996) details the exact type of medical information required for all cases.

incompetent. These additional documents may also include previous medical boards, the member's rebuttal, and the Comprehensive Clinical Evaluation Protocol evaluation or waiver, if appropriate.

Note the following military department–specific differences:

- The Departments of the Army and Navy medical boards include Standard Form 88/Standard Form 93, Report of Medical History.
- The Department of the Navy medical boards may include previous Limited Duty Boards and physician surrebuttals.

Patient administrators at the MTFs generally assist PEBLOs in compiling the necessary medical and nonmedical documents that constitute the comprehensive disability case file—that is, the medical board—before forwarding it to the PEB.

Note the following military department–specific differences:

- The Army job titles for what this report refers to as "patient administrators" include "patient administration staff members" and "MEB clerks" that assist PEBLOs.
- At the Department of the Navy medical centers, known as the "Big-8," PEBLOs focus on counseling service members whereas patient administrators compile the documentation for the medical boards.

Dictating the narrative summary triggers initial counseling by the PEBLOs.

Note the following military department–specific differences:

- Most Army PEBLOs are Army civilian employees, assigned to positions in the continental United States (CONUS). The Army typically assigns noncommissioned officers with backgrounds in patient administration to its limited medical PEBLO positions outside CONUS. Army PEBLOs are appointed by and work for the MTF commander, not the Physical Evaluation Board.
- The Department of the Navy assigns senior enlisted members (E-7 or above) with backgrounds in patient administration to PEBLO positions at the eight Navy medical centers. PEBLOs at the Big-8 are the only PEBLOs in any of the military departments that work for the Physical Evaluation Board. The Department of the Navy also assigns equivalent Navy civilian employees and enlisted members—called "disability evaluation counselors"—from a wide range of diverse specialties, such as nuclear machinist's mate, electrician, postal worker, electronic warfare technician, gas turbine electronic technician, and aviation ordinance technician, to collateral PEBLO duty at smaller MTFs; they work for the MTF commander.
- The Air Force also typically assigns enlisted service members with a background in the patient affairs medical career field to PEBLO duty, although it recently began reorganizing the PEBLO function from patient affairs in the MTFs to flight

medicine, which actually performs the medical examinations. Some Air Force PEBLOs are also Air Force civilian employees. Air Force PEBLOs also work for MTF commanders.

The PEBLOs advise service members regarding what to expect throughout all phases of the disability evaluation process, the significance and consequences of the determinations that are made, and the service member's rights, benefits, and entitlements.

Note the following military department–specific differences:

- The Army makes every effort to send members for pre-separation counseling 90 days prior to separation.
- The Department of the Navy PEBLOs funnel service members through the Navy Transition Assistance Program (TAP). PEBLOs present a Disability Transition Assistance Program, which is Part 1 of the TAP. Part 2 is mandated by law and managed by commanders.
- In the Air Force, as soon as it is evident that a service member will meet a Medical Evaluation Board, the PEBLO refers the member to the Military Personnel Flight for pre-separation counseling to satisfy the requirements of 10 U.S.C. 1142, although final disposition within the DES is unknown.

A Medical Evaluation Board—a clinical body of two or three physicians at an MTF—reviews the narrative summary and supporting addenda. One Medical Evaluation Board member is a psychiatrist when a psychiatric condition is under examination.

Note the following military department–specific differences:

- The Army Medical Evaluation Boards consist of two or three physicians plus a reviewing authority. They do not convene a "group board"; they pass the medical boards among the designated members, one at a time.
- Department of the Navy Medical Evaluation Boards also act by passing a medical board from one physician to the next until all three designated members have reviewed it.
- Only the Air Force actually *convenes* a group of three staff-rank physicians (that is, not interns or residents) in one place at one time to act on narrative summaries, with the MTF commander or designee as an approving authority.

The Medical Evaluation Board documents, under departmental regulations, the service member's medical status and duty limitations based on the medical diagnosis and prognosis found in the narrative summary. The Medical Evaluation Board evaluates and reports on the (1) diagnosis; (2) prognosis for return to full duty; (3) plan for further treatment, rehabilitation, or convalescence; (4) estimated length of time the disabling condition will exist; and (5) medical recommendations for the disposition of the service member. The Medical Evaluation Board determines if a reasonable

doubt exists of a service member's ability to meet medical retention standards to perform military duties.

Note the following military department–specific differences:

- Only the Army Medical Evaluation Boards determine the service member's ability to meet medical retention standards only for his or her *current* military occupational specialty.
- The Department of the Navy Medical Evaluation Board makes a clear statement of its opinion that the member's condition does or does not render the member "unable to continue naval service by reason of physical impairment" (Secretary of the Navy Instruction 1850.4D, 1998, p. 3-59).
- The Air Force Medical Evaluation Board relates the member's defects, capabilities, limitations, and prognosis to the military environment. Members must be able to perform military service in such a manner as to reasonably fulfill the purpose of their employment on active duty (U.S. Department of the Air Force Physical Disability Division, 1999, p. 9).

The Medical Evaluation Board recommends a case disposition based solely on a records review.[11] The Medical Evaluation Board may recommend

- return to duty
- referral to the PEB
- the case be returned to the physician(s) for further evaluation, treatment, or clarification
- referral to the parent service for review and disposition.

Note the following military department–specific differences:

- Department of the Navy Medical Evaluation Boards may also recommend a period of "light duty" or a period of temporary limited duty.
- If an Air Force Medical Evaluation Board finds an Air Force service member temporarily disqualified for worldwide duty, it may forward the case to the Medical Standards Branch for review and approval. The Medical Standards Branch may direct further observation or treatment. In these cases, the Medical Standards Branch gives the service member a Temporary 4 profile (4-T) and the case is reconsidered at a later date. The service member may remain on a 4-T profile for a maximum of one year. A service member who remains disqualified for worldwide duty at the end of one year on 4-T must be processed for Medical Evaluation Board/PEB evaluation (U.S. Department of the Air Force Instruction 48-123, 1994).

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[11]Throughout this report, the term "records review" means that the service member does not appear before the decisionmaking body; only the written record of the service member—the disability case file referred to as the "medical board"—represents the service member's case.

The Medical Evaluation Board approving authority reviews all Medical Evaluation Board decisions recorded in the medical boards before forwarding to the PEB. This approving authority is a senior physician, generally assigned or delegated by the MTF commander, and is not considered a member of the Medical Evaluation Board.

Note the following military department–specific difference:

- The Department of the Navy title for the Medical Evaluation Board approving authority position is "M.E.B. convening authority," although the Department of the Navy Medical Evaluation Board does not physically convene in one place to review medical boards.

When a Medical Evaluation Board report expresses a reasonable doubt of a service member's ability to fulfill the duties of his or her office, grade, rank, or rating, the MTF refers the medical board to the PEB for a determination of fitness and a disability rating for those found unfit.

DoD Instruction 1332.38 (1996) establishes the following time requirement goal for the medical evaluation phase of the DES: "When a physician initiates a Medical Evaluation Board, the processing time should normally not exceed 30 days from the date the Medical Evaluation Board report is dictated to the date it is received by the Physical Evaluation Board."

Note the following military department–specific difference:

- Secretary of the Navy Instruction 1850.4D (p. 1-11) restates the timeliness goal: "Medical Board reports referring members to the Physical Evaluation Board will be processed, dictated, and received by the Physical Evaluation Board within 30 days of the attending physician's desire to convene a medical board based on the doctor's opinion that the service member's return to full duty is unlikely and optimal medical benefits have been attained. *Delays of acceptance by the PEB for completion of case documentation requirements are not included within this time standard*" [emphasis added].

DoD Instruction 1332.38 establishes the following time requirement goal for Reserve component service members referred solely for a fitness determination on a non-duty-related condition: "For cases of Reserve component members referred solely for a fitness determination on a non-duty-related condition, processing time for conduct of Medical Evaluation Board or physical examination shall not exceed 90 calendar days."

Phase 2. Physical Disability Evaluation and Disposition

The PEB conducts the Physical Disability Evaluation process; the process consists of two levels of adjudication: Informal PEB adjudication and Formal PEB adjudication. The Informal PEB conducts a records review and issues findings and recommendations. Service members found unfit who choose to appeal the findings and recommendations of the Informal PEB have an opportunity to present their case in person

with legal representation at the Formal PEB, which then issues findings and recommendations.

PEB administrative action officers are the focal point for quality assurance during this phase. They (1) receive medical boards from MTFs, log them in, quality-check them for administrative sufficiency, send insufficient medical boards back to the referring MTF, and route sufficient ones to the Informal PEB; (2) notify appropriate service headquarters of pending PEB actions on service members; and (3) forward medical boards of appealed cases to the Formal PEB. The following sections of this chapter outline the operations of the two levels of PEB adjudication—Informal PEB adjudication and Formal PEB adjudication, plus final disposition from both.

Note the following military department–specific differences:

- The Army job titles for what this report refers to as "PEB administrative action officer" include "case analyst" and "recorder." Recorders are noncommissioned officers, warrant officers, or civilians of equivalent grades who work for the PEB.
- "Recorder" is also the job title in the Department of the Navy.
- The Air Force job title is "action officer"; nine GS-07s and one technical sergeant serve as action officers to support the Informal PEB. Unlike the other military departments, each action officer manages an individual case from the time it is logged in at the Informal PEB until the case is closed, a period which may cover several years, depending on the stability of the member's condition and the level of appellate review sought.

Informal Physical Evaluation Board. The Informal PEB consists of three voting members, including at least one physician, and one nonmedical officer. The physician(s) interpret(s) the diagnosis and prognosis from the Medical Evaluation Board. The nonmedical officer—typically a personnel officer—interprets the impact on the service member's unit from the member's inability to perform his or her duties as a result of the condition or impairment. A Reserve component officer fills one of the three voting positions when adjudicating a Reserve component case. When the board members cannot agree on findings or recommendations, the dissenting member may write a minority opinion that becomes part of the medical board.

Note the following military department–specific differences:

- Army Informal PEB composition normally includes a nonmedical officer president (O-6), one personnel management officer, and one physician who may be either civilian or military. The president and personnel management officer may be of any branch except the special branches. The personnel management officer is usually a Reserve or National Guard member. A Reserve component officer, otherwise qualified for PEB duty, serves on the informal board when it evaluates Reserve component cases. Likewise, female, minority, or enlisted representation on the Formal PEB is provided, when possible, upon request. The same members constitute both the Informal and Formal PEBs, which means the same members may adjudicate the same case on two different levels.

- Department of the Navy Informal PEB membership consists of one medical officer and two line officers, usually a Navy and Marine Corps officer. All members are senior military officers, O-6 preferred. One of the two line officers acts as the Informal PEB administrator, preferably the line officer from the member's service (Navy or Marine Corps).
- Air Force Informal PEB membership consists of two medical officers (O-6s) and one line officer, generally a personnel officer (O-5 or O-6), who is designated Informal PEB president.

The Informal PEB determines whether the service member is eligible for full adjudication or only a fitness finding for Reserve component non-duty related cases. It evaluates each case and issues a finding of each service member's fitness to perform the duties of his or her office, grade, rank, or rating on the basis of the preponderance of the evidence in the medical board.

Note the following military department–specific differences:

- The Army Informal PEB issues a finding of the service member's fitness to perform the duties of his or her "office, grade, rank, or rating and military occupational specialty."
- Air Force Informal PEB issues a finding of the service member's fitness to perform the duties of his or her "office, grade, or rank."

In each case, the Informal PEB weighs the nature and degree of the service member's condition or impairment as presented in the medical board against the requirements and duties expected of the service member's office, grade, rank, or rating, and the commander's assessment of the service member's duty performance.

The Informal PEB considers the following compensability criteria:

- Any injury or disease discovered after a service member enters active duty, with the exception of congenital and hereditary conditions, is presumed to have been incurred in the line of duty.
- Presumption that service incurred or service aggravated condition, and overcoming presumption.
- Line of duty determination (depending on the case—administrative, informal, or formal).

  Note the following military department–specific difference (to the LOD Determination):

  - The Naval Reserve uses the term *Notice of Eligibility* for the LOD Determination.
- Standard of proximate result applies to Reserve component members whose disability originated prior to September 24, 1996.

- Presumption of fitness, and overcoming presumption. Members with retirement dates and members who face higher tenure restrictions are presumed fit. Because these members qualify for length-of-service retirement, the potentially disabling condition is presumed not to be a reason for "early firing."
- Noncompliance (refusal of treatment).

Based on the information in the service member's medical board, the Informal PEB may find the member fit or unfit. The military departments each rely on different fitness criteria.

Note the following military department–specific differences:

- The Army PEB (both Informal and Formal) determines fitness based upon whether the record of evidence shows that the medical condition does or does not preclude reasonable performance of the duties required of the service member's office, grade, rank, or rating. It relies heavily on the performance data provided by the service member's immediate commander (DoD Instruction 1332.38, 1996, Part 3, paras. B and C [published version], and DoD Instruction 1332.38, 1996, Part 3, paras. E3.P3.2 and E3.P3.3 [electronic version];[12] AR 635-40, 1990, para. 4-19d[2]).
- The Department of the Navy determines fitness by relating the nature and degree of physical disability of the member to the requirements and duties that member may reasonably be expected to perform in his or her office, grade, rank, or rating. It published its fitness standards and criteria in Secretary of the Navy Instruction 1850.4D, 1998, pp. 3-13 through 3-17.
- The Air Force relies on the standards and criteria for determining fitness in DoD Directive 1332.18, para. C.3 (para. 3.3 in the electronic version) (U.S. Department of the Air Force Instruction 36-3212, 1998, p. 17). The Air Force Informal PEB may express its opinion concerning possible reclassification, but does not have the authority to direct reclassification, establish physical profile limitations or direct assignments (U.S. Department of the Air Force Physical Disability Division, 1999, p. 12).

If the Informal PEB finds a service member unfit and the service member does not have an LOD Determination of No (LOD-No) or a condition that existed prior to service, the Informal PEB assigns a code and rates the service member's degree of disability using the VASRD, the DoD Instruction 1332.39, Enclosure 3, or the current analogous codes established by a group of physicians from all three military depart-

[12]The Department of Defense Directive (DoDD) 1332.18 and Department of Defense Instruction (DoDI) 1332.38 documents posted on the DoD Web site use a different paragraph numbering system than the published paper documents. Primary participants reported that service member customers generally have easier access to the electronic version on the Web than to the published version, whereas primary participants who work with the system on a daily basis rely almost exclusively on the published paper versions. As a result, primary participants who respond to customer inquiries based on the electronic version of the DoD Directive and the DoD Instruction must translate the paragraph numbers in their published paper version to the paragraph numbers in the customer's electronic version.

ments and distributed to augment those published in Enclosure 3. The analogous codes supplement VASRD codes, which do not include all possible impairments that result from combat or many current medical diagnoses.

The range of recommendations available to an Informal PEB for a service member found unfit to perform the duties of the member's office, grade, rank, or rating is as follows:

- Stable condition, unfit
  - Discharge with severance pay if the disability is rated less than 30 percent and member has less than 20 years of service
  - Discharge without severance pay (in cases of LOD-No or Existed Prior to Service [EPTS])
  - Retire for disability if the disability is rated 30 percent or more or member has more than 20 years of service and is eligible for retirement
- Unstable condition, unfit
  - Place on Temporary Disability Retired List if the disability is rated 30 percent or more or the member has more than 20 years of service and is eligible for retirement.

The range of recommendations available to the Informal PEB for a service member found fit to perform the duties of the member's office, grade, rank, or rating, if the condition is stable, is as follows:

- Fit
  - Return to duty
  - Remove from TDRL and return to duty.

All three military departments exercise an administrative process for granting light or limited duty to a service member who is found fit but requires additional time to heal.

When the Informal PEB finds a service member *fit*, the PEB administrative action officers route the medical board back through the appropriate administrative channels to the MTF and notify the service member's PEBLO. The PEBLO notifies the service member of the findings, recommended disposition, and appeal options.

Note the following military department–specific differences:

- An Army service member has ten calendar days to make a decision regarding the Informal PEB findings and recommendations. A member found fit may elect either of the following options:
  - Concur
  - Nonconcur, with or without rebuttal.

If the service member concurs, the PEB president approves the proceedings for the Secretary of the Army. The PEB recorder forwards the medical board to the Physical Disability Branch within the Army Physical Disability Agency for final disposition.

Unless a minority report was entered, if the service member nonconcurs with the finding without submitting a rebuttal, the PEB president has approval authority for the Secretary of the Army and forwards the case to the Physical Disability Branch for final disposition. The Army Physical Disability Agency must approve all cases that include a minority report before final disposition. If the service member nonconcurs and submits a statement or rebuttal to the recommended findings without asking for a formal hearing, the PEB president responds in writing to the service member, normally within three days. If the service member's rebuttal does not result in a change to the Informal PEB findings, the response explains the Informal PEB's decision to adhere to the earlier findings. The service member is advised that the rebuttal will be included in the medical board and considered in the review action by the Army Physical Disability Agency. A copy of the PEB president's letter is included in the medical board that is forwarded to the Army Physical Disability Agency for final review.

- A Department of the Navy service member has 15 calendar days in which to make a decision regarding the Informal PEB findings and recommendations; acceptance is presumed on the sixteenth day after the receipt of findings. A member found fit may elect either of the following options:

  - Accept the fit finding and continue service
  - Disagree with the finding and request reconsideration by the Informal PEB.

  Reconsideration may relate to the same diagnosis or a new diagnosis. A member offering new medical information, or a significant nonmedical assessment that was not previously available or considered, is eligible to have the Informal PEB reconsider the case. The member must also present a new nonmedical assessment. In requesting reconsideration, the member must also submit a statement regarding his or her desire for a Formal PEB if the findings are unchanged. If the new information does not change the results of the Informal PEB finding, the PEB president may grant a member a Formal PEB. The member found fit does not have a right to a Formal PEB. If the member does not request a hearing, or if the hearing request is denied, the Informal PEB findings become final. If, upon reconsideration, the finding is changed to unfit, the member receives new notification and is presented with the applicable options.

- Air Force members found fit do not have a right to an appeal process because they have not been "fired." However, the Informal PEB will review the cases again at the request of the commander of the referring MTF, if the commander believes that important evidence was omitted from the previous medical board that was sent to the Informal PEB.

When the Informal PEB finds the service member unfit, it determines whether the service member is eligible for other special considerations, such as permanent limited duty, as an exception to policy.

Note the following military department–specific difference:

- The Army Informal PEB determines whether the service member is eligible for Temporary Early Retirement Authority or Reserve component member early qualification for retired pay at age 60.
- Only the Department of the Navy limits the amount of limited duty time awarded by the PEB, which together with the service headquarters has authority to grant permanent limited duty of 60 days or less for Marines and 90 days or less for Navy members.

The Informal PEB determines if the disabling condition meets the criteria for Instrumentality of War issues, such as exemption of disability retired or severance pay from gross federal income tax, eligibility for civil service preference status, and exemption from the Dual Compensation Act.[13]

When the Informal PEB finds a service member unfit, the PEB administrative action officers notify the PEBLO who counsels the service member, in person when possible, on the findings, disposition recommendation, implications, and appeal options. Depending on the option the service member elects, the PEB administrative action officers route the medical board to the appropriate review authority, personnel headquarters, or the Formal PEB. Depending on military department policy, the service member has from three duty days to 15 calendar days to elect options.

Note the following military department–specific differences:

- An Army service member has ten calendar days to make a decision regarding the Informal PEB findings and recommendations. A member found *unfit* may elect from among the following options:

– Concur

– Nonconcur with or without rebuttal

– Demand Formal PEB (unfit findings only).

  An Army Formal PEB is a new hearing; it does not start with or refine the findings of the Informal PEB.

  If the service member concurs, the PEB president approves the proceedings for the Secretary of the Army. The PEB recorder forwards the medical board to the Physical Disability Branch within the Army Physical Disability Agency for final disposition.

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[13]The Dual Compensation Act prohibited military officer retirees from collecting full military retirement pay in addition to full pay as a federal civilian employee, so-called double-dipping. During the course of this study, the 1999 National Defense Authorization Act for fiscal year 2000 repealed the reduction in retired pay for military retirees employed in civilian positions, effective October 1, 1999.

Unless a minority report was entered, if the service member nonconcurs with the finding without submitting a rebuttal, the PEB president has approval authority for the Secretary of the Army and forwards the case to the Physical Disability Branch for final disposition. The Army Physical Disability Agency must approve all cases that include a minority report before final disposition. If the service member nonconcurs and submits a statement or rebuttal to the recommended findings without asking for a formal hearing, the PEB president responds in writing to the service member, normally within three days. If the service member's rebuttal does not result in a change to the Informal PEB findings, the response explains the Informal PEB's decision to adhere to the earlier findings. The service member is advised that the rebuttal will be included in the medical board and considered in the review action by the Army Physical Disability Agency. A copy of the PEB president's letter is included in the medical board that is forwarded to the Army Physical Disability Agency for final review. If the service member nonconcurs with the findings and recommendations with a statement of rebuttal and demands a formal hearing, the PEB may reconsider its findings and recommendations in light of the service member's statement of rebuttal. If the Informal PEB agrees with the service member and modifies the findings and recommendations, the PEB sends the amended findings to the member's PEBLO. The PEBLO then notifies the service member of the change. The service member has ten calendar days to make his or her new election. If the service member accepts the revised findings, the case is forwarded to the Physical Disability Branch for final disposition. If the service member does not accept the revised findings or the Informal PEB does not change its earlier findings, the case is scheduled for a formal hearing.

- A Department of the Navy service member has 15 calendar days to make a decision regarding the Informal PEB findings and recommendations; acceptance is presumed on the sixteenth day after the receipt of findings. A member found unfit may do any of the following:

- Unconditionally accept the findings
- Conditionally accept the findings
- Demand a hearing before the Formal PEB.

In the case of unconditional acceptance, the case is forwarded to the PEB president who issues a Notice of Decision to the appropriate service headquarters. In the case of conditional acceptance, the member agrees to accept the findings if the condition requested is met (such as a specified period of permanent limited duty or a specified separation or retirement date). When filing a conditional acceptance, the member must indicate if he or she desires a Formal PEB if the condition is not met. A member found unfit who nonconcurs with the Informal PEB findings may demand a Formal PEB hearing.

- An Air Force service member has three duty days to decide whether to accept or appeal the recommendations. A member found *unfit* may do either one of the following:

- Agree with the findings

- Disagree with the findings and request a Formal PEB hearing (U.S. Department of the Air Force, Physical Disability Division, p. 11).

  If the member accepts the finding and recommendations, he or she signs a form that is sent back to the Disability Operations Branch and the medical board is forwarded to the Secretary of the Air Force Personnel Council. Final disposition includes outprocessing the service member from the Air Force. If the member decides to appeal the recommendations, the action officer assigned to the case schedules an appointment for the Formal PEB within two to three weeks, forwards the medical board to the Formal PEB, and advises the PEBLO at the referring MTF.

In two of the three military departments' DESs, the officer (O-6) in charge of the department's PEB board process (called the "PEB board approving authority" in this report) reviews the Informal PEB findings and disposition recommendations for every medical board.

Note the following military department–specific differences:

- No one person reviews all Army Informal PEB findings and recommendations. However, the Army Physical Disability Agency is responsible for reviewing and confirming Informal PEB actions. The Army Physical Disability Agency reviews those cases in which the service member disagrees with the findings of the Informal PEB and submits a rebuttal. If the agency changes the findings of the Informal PEB and the service member nonconcurs with a rebuttal, the case is forwarded to the Army Physical Disability Appeal Board for final decision. The Army Physical Disability Agency headquarters also conducts mandatory records reviews for quality assurance of the following cases:

- All general officers and medical corps officers found unfit
- All cases in which the service member nonconcurred, with or without a rebuttal, and consideration of the rebuttal did not result in a change in PEB findings and recommendations
- All cases in which a PEB member submitted a minority report
- All cases of members assigned to the Army Physical Disability Agency
- Any case previously reviewed
- Command directed quality reviews on special-interest cases, such as HIV.

- The Army Physical Disability Agency may do the following:

- Concur with the findings and recommendations of the Informal PEB or make minor changes or corrections that do not affect the recommended disposition of the soldier, or lower the combined percentage rating
- Return the case to the PEB for reconsideration, clarification, further investigation, a formal hearing, or other action when the case records show that such action is in the best interest of the service member or the Army

  - Issue revised findings providing for a change in disposition of the service member or change in the service member's disability rating
  - Refer the case to the Army Physical Disability Appeal Board.
- The Department of the Navy PEB president, who oversees all Navy PEBs (both Informal and Formal), reviews all Informal PEB findings and disposition recommendations and ensures each case is administratively and legally sufficient. If he or she concurs, the recorder sends a findings letter to the PEBLO to brief the service member. If the service member does not concur, he or she may modify or cancel the findings letter and notification of decision letters and direct appropriate substitute disposition.
- The Chief, Air Force Physical Disability Division, who oversees both the Informal and Formal PEBs, reviews all Informal PEB case findings and recommendations. If the Chief, Air Force Physical Disability Division approves the PEB findings and recommendations, a PEB administrative action officer sends a findings letter to the PEBLO who then informs the service member. If the Chief, Air Force Physical Disability Division does not approve the PEB findings and recommendations, he or she forwards the case directly to the Formal PEB.

A service member found unfit who disagrees with the findings and recommendations of the Informal PEB has a legal right, with the assistance of an attorney at no cost to the member, to appeal his or her case to the Formal PEB.

Formal Physical Evaluation Board. The Formal PEB consists of three voting members, including at least one physician, and one nonmedical officer. The physician(s) interpret(s) the medical diagnosis and prognosis. The nonmedical officer—typically a personnel officer—interprets the impact of the member's inability to perform his or her duties as a result of the condition or impairment on the service member's unit. A Reserve component officer fills one of the three voting positions when adjudicating a Reserve component case.

A service member may choose representation by an attorney from the Office of the Judge Advocate General at no cost to the member. A service member may also choose to hire a civilian attorney at his or her own expense.

A service member spends one to three working days with an attorney to prepare for his or her formal hearing, depending on military department policy.

Note the following military department–specific differences:

- An Army service member is given a minimum of three working days to prepare his or her case with an attorney. If more time is required, the service member can request an extension from the PEB president.
- The Department of the Navy encourages a service member to contact his or her attorney by phone in order to start preparing the case as soon as the service member decides to appeal and before arriving at the Formal PEB. The

Department of the Navy service member meets with his or her attorney the day before the hearing.

- An Air Force service member is given two days to prepare a case with his or her attorney at the Formal PEB location.

The service member's attorney confers with and fully advises the member of legal and other substantive considerations for his or her case. The attorney represents the service member before the Formal PEB, presenting information and arguments in support of the service member's case. The attorney also arranges for the presence of desired witnesses and evidence in support of the member's case, interviews witnesses prior to the formal hearing, and questions them during the hearing.

The Formal PEB is formally structured and nonadversarial in nature. The proceedings are generally audiotaped.

Note the following military department–specific difference:

- The Air Force both audiotapes and videotapes the proceedings and gives the member a copy of the audiotape before he or she departs the site of the Formal PEB.

The board members review the evidence in the medical board prior to the formal hearing.

Note the following military department–specific difference:

- Some Army formal hearings are held via videoconference.

The service member is called into the formal hearing chamber and sworn in. Any additional documents provided by the service member are entered into evidence. The service member's attorney enters the member's plea and the board members question the service member about his or her medical condition of referral and its impact on the service member's current activities including work, school, and recreation.

Note the following military department–specific difference:

- Department of the Navy physician board members may conduct medical examinations on the service member during the formal hearing; Army boards do not include this practice.

At the end of the questioning, the board provides the member with an opportunity to add any additional information that would impact his or her case. Upon completing the open hearing, the board closes for deliberation and the service member and his or her attorney leave the room. The Formal PEB members consult in private to agree upon a fitness decision and disposition recommendation and determine if any additional information entered into evidence impacts Informal PEB administrative decisions.

The range of dispositions available to the Formal PEB is the same as that available to the Informal PEB.

Any dissenting member of a Formal PEB may submit a minority opinion citing particular areas in which he or she disagrees with the action of the formal board. The minority opinion becomes part of the medical board case file.

Upon completion of the deliberations, the board reopens, calls the service member and attorney back into the hearing chamber, and informs the service member of the findings and recommendations. The service member and attorney then depart the chamber.

The attorney counsels the service member regarding Formal PEB findings and options available to the member and recommends courses of action that are most favorable to the member and that are consistent with the letter and intent of statutes, instructions, and other policy documents addressing disability evaluation and administration. The attorney advises the service member and assists, if asked, in the preparation and submission of a request for permanent limited duty, and prepares or assists in the preparation of a rebuttal at the request of the service member. In the case of incompetent service members, the attorney fully informs the court-appointed guardian, or if no guardian has been appointed by a court, the service member's spouse or next of kin, as appropriate, if the wishes of the spouse or next of kin do not conflict with the proper exercise of the responsibilities of the attorney concerning the member's best interests.

The service member may concur or nonconcur, with or without a rebuttal. The member has a right to appeal the findings and recommendations of the Formal PEB.

Depending on military department policy, the service member has zero to 15 days to elect options.

Note the following military department–specific differences:

- An Army service member may concur with the findings and recommendations or nonconcur with them, with or without rebuttal. He or she has ten calendar days to submit a rebuttal. A rebuttal must be based on one of the following issues:
  - The decision of the PEB was based on fraud, collusion, misrepresentation, or other misconduct
  - Mistake of law
  - The service member did not receive a full and fair hearing
  - Substantial new evidence exists.
- When practical, a Department of the Navy service member is notified of the findings either in open session or by his or her attorney, in person, prior to leaving the Formal PEB site. The attorney then counsels the service member regarding the Formal PEB's recommendations. A service member is notified that the formal board's findings are subject to review for administrative and legal sufficiency before issuance by the PEB president. After the review, the service mem-

ber later receives the final Formal PEB findings and the rationale for the findings from the PEB president via certified mail. A service member may choose to accept the Formal PEB findings or submit a Petition for Relief to the Director, Naval Council of Personnel Board, who is the next level of appeal. The member has 15 calendar days from the date of receipt of the Formal PEB findings to submit a Petition for Relief. If the service member accepts the findings and recommendations, the case is finalized and the PEB issues a Notice of Decision to the Chief of Navy Personnel or to the Commandant, Marine Corps (Manpower and Reserve Affairs).

- When the Air Force Formal PEB members reach agreement on a fitness and disposition recommendation, they call the service member and the member's attorney back into the chambers and read the findings and recommendations, at which point the formal board concludes. The service member must sign a document stating that he or she either accepts or chooses to appeal the findings and recommendations. If the service member leaves the premises without signing the document, it is assumed that he or she chooses to appeal.

In the Departments of the Navy and the Air Force, the PEB approving authority reviews the Formal PEB findings and disposition recommendations for every medical board.

Note the following military department–specific difference:

- In the Army, the president of the PEB that heard the case reviews the board's findings and recommendations. However, the Army Physical Disability Agency does conduct mandatory reviews of the cases mentioned earlier.

DoD Instruction 1332.38 establishes the following time requirement goal for the physical evaluation and disposition phase, including the appellate review and disposition beyond the PEB phase (discussed in the next section) of the DES: "Upon receipt of the [medical board] or physical evaluation report by the [Physical Evaluation Board], the processing time to the date of the final reviewing authority as prescribed by the Secretary of the Military Department should normally be no more than 40 days."

Phase 3. Appellate Review and Disposition Beyond the Physical Evaluation Board

By law (10 U.S.C., Ch. 61, sec. 1214), the military departments may not separate or retire (for disability) a service member without a full and fair hearing if he or she demands it. The Formal PEB meets the requirement of the law. However, in addition to the statutory requirement, the military departments extend two to three additional appellate review opportunities to the service member. Following discharge or permanent retirement, a service member who remains dissatisfied may submit a petition to the appropriate military department's Board of Correction of Military Records.

Generally, the additional appellate review boards have the same range of disposition options as the PEBs.

Note the following military department–specific differences:

- The Army provides three levels of appellate review beyond the PEB; the last two levels are components of the Army Council of Review Boards.
  - Army Physical Disability Agency
  - Army Physical Disability Appeal Board
  - Army Disability Rating Review Board.

  The Army Physical Disability Agency reviews those cases in which the service member disagrees with the findings of the Formal PEB and submits a rebuttal. If the agency changes the findings of the Formal PEB and the service member nonconcurs with a rebuttal, the case is forwarded to the Army Physical Disability Appeal Board for final decision. The Army Physical Disability Appeal Board reviews disability evaluation cases forwarded by the Commanding General, Army Physical Disability Agency. The Army Disability Rating Review Board reviews disability percentage ratings at the request of a service member who was retired because of physical disability.
- The Department of the Navy provides two levels of appellate review beyond the PEB:
  - Director, Naval Council of Personnel Boards
  - Officer Disability Review Board.

  A Department of the Navy service member who disagrees with the findings and recommendations of the Formal PEB may submit a PFR to the next level of appellate review beyond the Formal PEB, the Director, Naval Council of Personnel Boards. The Director, Naval Council of Personnel Boards cannot reduce the final disability rating assigned by the Formal PEB unless the member is offered an additional appearance before a Formal PEB whose members have not previously ruled on the case (U.S. Department of the Navy, 1998, p. 5-2).

  The Officer Disability Review Board reviews a limited class of disability cases wherein officers were retired or released from active duty without pay for physical disability (U.S. Department of the Navy, 1998, p. 7-1).
- The Air Force provides two levels of appellate review beyond the PEB; both are components of the Air Force Personnel Council (AFPC):
  - Air Force Personnel Board (AFPB)
  - Physical Disability Appeals Board (PDAB).

  An Air Force service member who remains dissatisfied with the Formal PEB findings and recommendations may appeal his or her case to the AFPB, which consists of five senior officers, at least one of which is a medical officer. The AFPB conducts a records review of the case in closed session. The board members re-

view all material examined by the Formal PEB, the PEB report, and the service member's rebuttal. The physician on the board is the service member's advocate. The physician reads all of the information in the case file and presents a summary to the rest of the board. He or she answers the board's questions, but makes no decisions or recommendations. The rest of the members vote secretly; majority vote rules. The AFPB may change the findings of the Formal PEB.

If the AFPB agrees with the Formal PEB or grants the service member's appeal, the Secretary of the AFPC finalizes the case. Any other major change results in revised findings and recommendations, which the service member may choose to appeal at one final level, the PDAB.[14] This board consists of five senior officers, including at least two medical officers, and conducts a records review in closed session. One officer briefs the case to the other members. They consider the entire medical board plus the service member's rebuttal. The PDAB issues findings from the same range as all of the preceding boards. Majority vote rules. The PDAB's decision on the case is final.

Phase 4. Final Disposition by the Appropriate Personnel Authorities

After the PEB or another appellate review board makes the final disposition decision, the personnel community returns the service member to duty or outprocesses and issues orders for those separated or retired for disability.

Note the following military department–specific differences:

- The Total Army Personnel Command makes final disposition of disability cases. The Physical Disability Branch within the Physical Disability Agency calculates separation and retirement dates and generates orders.
- Navy Personnel Command handles the final administrative discharge of disability cases. The effective date of retirement or separation because of physical disability (either permanent or temporary) is normally within four to six weeks, on average, after issuance of the "Notification of Decision." The four- to six-week elapsed-time standard, however, is a guideline and not an inflexible rule. It may be exceeded by the Chief of Naval Personnel or the Commandant of the Marine Corps—Manpower Management Division, Separation and Retirement Branch, Disability Separation and Retirement Section in circumstances such as when there is a severe hardship on the member; when the member who is unable to sell earned leave takes the earned leave in lieu of selling it; infeasibility, such as when there is longer lead time for properly vacating government quarters or arranging movement of household effects; and adverse effect on the service such as when the four- to six-week standard precludes contact relief of officers in

[14]The Department of the Air Force is looking at doing away with this last level of appeal. It processed about a dozen cases at the Physical Disability Appeals Board level in 1998 and no findings and recommendations changed. Senior Air Force primary participants note that this level of review does not seem to add any value and it slows down case processing by a month.

command or other key billets (Secretary of the Navy Instruction 1850.4D, 1998, p. 1-11).

- The Secretary of the Air Force Personnel Council (SAFPC) handles the final disposition of each disability case. The Director, SAFPC, is empowered to determine appropriate disposition and announce the final decision of the Secretary. In turn, the SAFPC has designated certain key officials in the U.S. Air Force Physical Disability Division as Special Assistants to the Director, SAFPC. These assistants have the authority to finalize cases and announce the final secretarial determination in those cases not otherwise required to be finalized at SAFPC level.

Setting aside the stated purpose and set of desired system outcomes for the DES proposed earlier in this chapter, Chapter 4 presents our issues-driven analysis of instances of variability in disability policy application across and within military departments, plus recommended interventions to achieve more-consistent policy application. Chapters 5 and 6 shift from the issues-driven approach presented in Chapter 4 back to the recommended purpose-driven approach. The latter approach relies on the stated purpose and set of desired outcomes proposed in this chapter in order to present the major recommendations of this report: interventions in training and management information system deployment.

Chapter Four

ISSUES AND INTERVENTIONS FOR ACHIEVING CONSISTENT POLICY APPLICATION

In Chapter 3, we propose a purpose and set of desired outcomes for the Disability Evaluation System. Chapters 5 and 6 fully develop this top-down, purpose-driven approach to conducting the DES training needs analysis that lead to our training and management information system recommendations. This chapter, however, presents our bottom-up, issues-driven analysis as part of a comprehensive plan to achieve consistent application of disability policy which, likewise, informed our recommendations.

Based on our attending the military departments' major training events and conducting numerous interviews with diverse primary participants[1] in the course of our study, we identified dozens of instances of variability in policy application across or within the military departments. We interviewed policymakers and administrators from both the personnel and medical communities, PEB members, and attorneys from all three military departments. We also spoke informally with PEBLOs and patient administrators at PEBLO workshops.

We captured these instances of variability in policy application—as well as problems identified by the primary participants—in the form of *issues* to be resolved. For example, three instances of variation in policy application are expressed as the following three issues: military departments describe the purpose of the Disability Evaluation System differently; no Disability Evaluation System process owner exists; and, none of the primary participants (except the PEBLOs in the Department of the Navy medical centers) in the medical evaluation phase of the Disability Evaluation System work for the O-6 who oversees the Physical Evaluation Board.[2] Appendix C summarizes the complete list of issues.

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[1]For the purposes of this study, we identified 12 primary participant populations: PEBLOs and disability evaluation counselors; patient administrators; physicians at MTFs; Medical Evaluation Board members at MTFs; Medical Evaluation Board approving authorities at MTFs; PEB administrative action officers; PEB members; PEB approving authorities; appellate review board members beyond the formal PEB; active component unit commanders; Reserve component commanders; and attorneys who represent service members during appeals.

[2]The O-6s who are assigned to oversee the military departments' PEBs share no titles in common. The Army O-6's title is Deputy Commander, Army Physical Disability Agency; the Department of the Navy O-6's title is President, Physical Evaluation Board; and the Air Force O-6's title is, Chief, Air Force Physical Disability Division. For convenience, we created the title PEB Approving Authority to apply to all three military departments' O-6s. This title parallels the Medical Evaluation Board Approving Authority and it

This chapter describes our analysis of all the issues and the recommended interventions to move toward more-consistent application of disability policy. We considered addressing each of the issues individually; however, many of the issues are interrelated and others require interventions that are common across more than one issue. Consequently, to develop a comprehensive plan to achieve consistent application of disability policy, we used a variation of *goal fabric analysis.*

Our application of goal fabric analysis suggested ten broad interventions, each consisting of specific actions for resolving the particular issues. Because the recommended interventions are based on reported or observed instances of inconsistent policy application—information that is not necessarily complete, objective, or empirically based—we expect that the interventions are not as finely tuned as they otherwise might be.

This chapter ends with introducing a shift in viewpoint—from a focus on ensuring consistent policy application to a focus on improving system performance.

GOAL FABRIC ANALYSIS OVERVIEW

Goal fabric analysis is a "bottom-up" planning tool for identifying actions needed to address a diverse set of issues and organizing those actions into an overall plan.[3] In other words, the tool is well suited to the task at hand in this study. It provides a context within which to thoroughly identify issues and necessary actions and then design a comprehensive plan around those actions. Goal fabric analysis does this by tying the issues to the desired results and tying the results to both the specific actions needed to bring about those results and the specific organizational objectives and goals.

As a prelude to employing the goal fabric analysis, we conducted an environmental assessment by recording notes on how the primary participants describe the operation of the DES. This assessment highlighted differences in how the primary participants view disability policy and its application, how well the primary participants are prepared to carry out their responsibilities, and differences in the problems perceived by the primary participants. We recorded each of their differences (for example, differences in the statement of purpose of the DES among the military departments or in the interpretation of standards contained in the DoD Directive or Instruction) and recorded each significant problem as an "issue." The issues were the starting point for employing the goal fabric analysis framework, which is displayed in Figure 4.1.

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allows us to easily differentiate the PEB Approving Authority primary participant population from other primary participant populations of the DES when we focus on training in later chapters.

[3]To learn more about goal-fabric analysis see Gulick and Kuskey (n.d.).

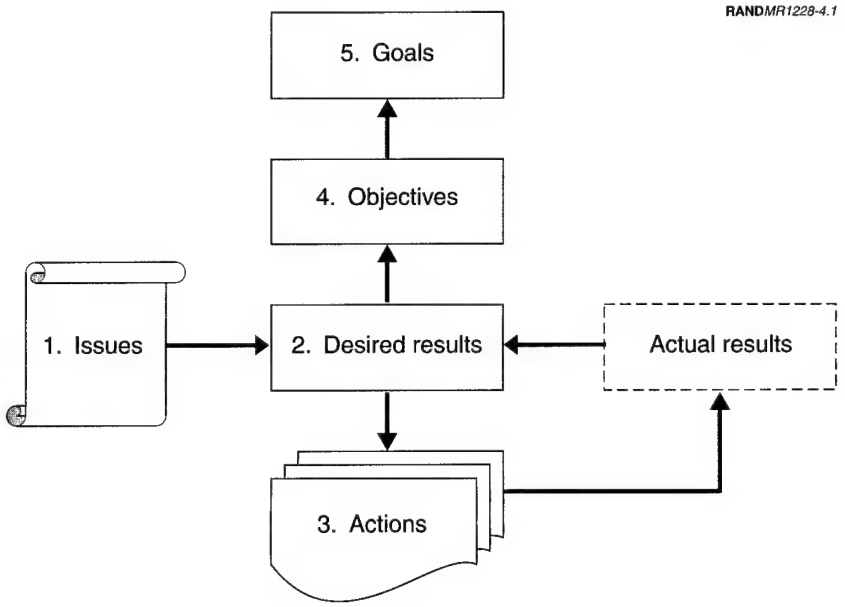

Figure 4.1—Goal Fabric Analysis Framework

For each issue, we asked the same question: What would we observe (in relation to the issue) if the difference were eliminated or the problem were solved? We called this observation the "desired result." We arrived at a desired result for each distinct issue.

In the next step, we asked two separate questions for each desired result. First, what specific actions would bring about the desired result? We identified a single action for some results, identified several parallel or serial actions for other results, and posited alternative actions to achieve yet other results (which we evaluated in a later stage). Second, we asked, if the desired result were accomplished, what objective would it serve? We identified eight objectives that appear to span the desired results. Multiple desired results serve each objective, and some desired results serve multiple objectives. This multiplicity of interactions is why this framework is called a goal "fabric."

In the final step of employing the framework, we asked, if the individual objectives were achieved, what broad organizational goals would they serve? We identified three broad-based goals. These goals support an implicit superordinate goal that we state simply as: Ensure the consistent application of disability policy within and across the military departments where appropriate. This analysis focused on identifying "desired results" and the actions necessary to accomplish the desired results—in other words, formulating a near-term plan of action. However, implementation of the recommendations based on this analysis must include actions to identify and measure "actual results," as illustrated in Figure 4.1. Appendix D presents a specific example of the goal fabric analysis framework development and delineates the full set of objectives and goals the analysis evoked.

The goal fabric analysis process may appear to unfold in reverse order, presuming that an organization *should* start with a goal (the top of most strategic planning frameworks) and work "down" through objectives and desired results to identify actions. Generally, we would agree with this observation; however, we found no established and shared set of objectives or goals organization-wide (or even a shared statement of purpose) within the OSD or military departments.[4] The strength of the goal fabric framework lies precisely in its capability to make explicit the objectives and goals that underlie a recommended set of actions.

Although the goal fabric analysis starts at the bottom with issues and Figure 4.1 suggests the process is unidirectional, it is in fact iterative. The process begins with identifying issues, then in turn formulating desired results, actions, objectives, and goals. When the goals have been formulated based on a bottom-up analysis, the process begins to iterate, starting at the "top" with each goal identified and then asking (1) whether the goal would be accomplished if the supporting objectives were successfully achieved; (2) whether all the necessary objectives were identified; and (3) whether all identified objectives were necessary for accomplishing the goals. The iteration continues, asking (1) whether each objective would be accomplished if the supporting desired results were obtained; (2) whether all the necessary results were identified; and (3) whether all identified results were necessary. This iterative procedure results in a more robust set of desired results, objectives, and goals in which to organize the necessary actions.

The product of this goal fabric analysis comprises ten categories of interventions (each composed of similar actions) together with assignment of responsibility. The analysis is couched in terms of the goals and objectives the actions are designed to achieve. Through this iterative process, a goal fabric analysis evokes the plan's overall goal (in this case, to ensure the consistent application of disability policy within and across the military departments where appropriate) and links the goal to the many actions necessary to achieve it. In the same way, the analysis prioritizes the necessary actions and their desired results in the larger context of the objectives they are intended to serve. In effect, the goal fabric analysis produces a near-term plan that management uses to ensure that the interventions are carried out.

Finally, with this near-term plan in place, the OSD can monitor the plan's implementation by focusing on the actual results of the actions taken. This is conveyed by the loop shown on the right side of Figure 4.1.

APPLYING GOAL FABRIC ANALYSIS TO RESOLVE IDENTIFIED ISSUES

To apply goal fabric analysis to the issues at hand, we employed a spreadsheet that (1) linked issues to desired results; (2) linked desired results to both actions to bring about those results and the objective(s) the results support; and (3) linked objectives

[4]In fact, as discussed in the final section of this chapter, we employ just such a top-down approach, using the purpose and set of outcomes proposed in Chapter 3, to develop recommendations for training and a management information system.

to the overall goals they support. This goal fabric model allowed us to group the actions together in different ways, while always retaining the link to the issues from which they originated and the higher order they serve.

Ten categories of interventions evolved as the most useful means of resolving the identified issues. Each intervention category, as follows, contains similar types of actions, many of which build on other actions in the same or different categories:

- Assistant Secretary of Defense Decisions
- Policy Guidance
- Organizational Changes
- Personnel Policy
- Personnel Management
- Training
- Information Source Development
- Management Information System Deployment
- Process
- Incentives.

These intervention categories cut across the various phases of the DES, the primary participant populations, and the objectives and goals evoked through the goal fabric analysis. Nevertheless, we found that organizing the necessary actions into ten intervention categories was the best means to present a comprehensive plan to the OSD. The OSD could thereby use the plan to move toward a more consistent application of disability policy based on the instances (that is, the issues) that exist today.

The issues-driven goal fabric analysis reinforced the importance of training DES participants—the genesis of this study—and management information system deployment as key interventions to ensure consistent application of disability policy across and within military departments (the management information system is discussed in Chapter 6). A separate purpose-driven analysis indicated that these two interventions are also keys to improving overall system performance.

This study also called for developing a process to monitor the effectiveness of the changes in training and other interventions, which led to the recommended management information system. Chapters 5 and 6 discuss the training and management information system deployment interventions in more depth. These two interventions are the most resource intensive of the ten intervention categories, which are covered in the following sections, and offer the greatest prospects for increasing overall system performance.

Appendix E groups the actions by intervention categories and by the objectives they support.

Assistant Secretary of Defense Decisions Intervention

The Assistant Secretary of Defense Decisions intervention focuses on two types of ASD decisions: (1) those that result in a common understanding of the purpose of the DES and (2) those that result in a common understanding of the standards for operationalizing disability policy. With regard to the first type of decision, the variations in the operational characteristics of the DES across the military departments, and the differences in the primary participants' observations on these variations, stem in large part from varying perspectives on the purpose of the DES.

A common, shared, and clearly articulated statement of the purpose of the DES is critical to the consistent application of disability policy. Consequently, we recommend that, as the first intervention, the ASD/FMP, in coordination with the ASD/RA and the ASD/HA, decide on an explicit statement of the purpose of the DES. The ASD/FMP should direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which the three ASDs can make a decision.

In addition, we found that primary participants in the medical evaluation phase and physical disability evaluation phase of the DES perceived major problems with each other's phase of the system (see the issues in Appendix C). We believe these perceptions stem from a mutual lack of understanding of the purpose and role of the Medical Evaluation Board despite the changes and information in DoD Instructions 1332.38 and 1332.39. Consequently, we recommend that the ASD/FMP, in coordination with the ASD/RA and the ASD/HA, decide on a statement of purpose for the Medical Evaluation Board. The same small group of experienced DES experts representing the military departments' PEBs and the Office of the Surgeons General should also produce recommendations upon which the three ASDs can decide upon a mutually acceptable statement of the purpose of the Medical Evaluation Board (not to be confused with the medical board case file) within the overall process.

These two ASD decisions are critical; they must be made first because they inform all of the other ASD decisions that follow. Although we would have preferred to recommend specific actions in all ten categories of interventions, we did not do so because without a clearly defined and mutually understood DES purpose statement, no effective criteria exist to choose among alternative recommendations.[5]

With regard to the second type of action stemming from this category of intervention—ASD decisions that result in a common understanding of the standards for operationalizing disability policy—primary participants cited numerous examples in which primary participants in the DES received little or no guidance, or ambiguous instructions, regarding the specific standards to employ despite the changes and information in DoD Instructions 1332.38 and 1332.39. The first eight issues in

[5]Although we propose a specific stated purpose for the DES in Chapter 3 in order to present a methodology for developing the training intervention and set of metrics for use in a management information system, we believe the DoD itself should apply that methodology to the DES purpose statement the three ASDs decide upon.

Appendix C form the basis for these recommendations. For the Medical Evaluation Board, the issues fell in two areas: the standards for referring medical boards to the PEBs and time frames for initiating Medical Evaluation Boards.

We recommend that the ASD/FMP, in coordination with the ASD/RA and the ASD/HA, decide on appropriate standards for referring medical boards to the PEB and appropriate time frames for initiating Medical Evaluation Boards. The standards for referring medical boards to the PEB should allow for variations among military departments based on their different missions and requirements; however, these allowable variations and the reasons for them should be clearly enunciated. The ASD/FMP should direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and the Office of the Surgeons General to produce recommendations upon which the three ASDs can make the decision.

In a somewhat different context, we recommend that the ASD/FMP, in coordination with the ASD/RA and the ASD/HA, decide on mechanisms for seamless transmission of medical boards from one military department to another. These mechanisms should result in data that is needed and formatted to expeditiously incorporate a medical board from one military department into the PEB of another. The ASD/FPM should direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and the Office of the Surgeons General to produce recommendations upon which the three ASDs can make the decision.

Numerous primary participants in the DES expressed confusion and frustration because they receive little or no guidance, or ambiguous instructions, regarding the specific standards to employ despite the changes and information in DoD Instructions 1332.38 and 1332.39. For the PEBs, the issues covered four areas: (1) the reasons for nondeployability, and the use of nondeployability in determinations of fitness; (2) more broadly, the standards for determining fitness; (3) aspects of the information used by the PEB to determine fitness and disability ratings; and (4) the amount of time authorized to a service member to make an election following a PEB decision.

We recommend that the ASD/FMP, in coordination with the ASD/RA and the ASD/HA, decide on appropriate standards for determining fitness; the information the PEB should use for determining fitness and disability rating; and a consistent period of time among the services to allow the service member to elect options following a PEB decision. The ASD/FMP should direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and the Office of the Surgeons General to produce recommendations upon which the three ASDs can make a decision.

As a prelude to making recommendations, the small group of DES experts should examine and determine appropriate criteria for nondeployability and use of nondeployability in determinations of fitness. The standard agreed upon should accommodate variations among military departments based on their different missions and requirements; however, the standard should clearly enunciate the allowable varia-

tions and the reasons for them. The group should consider and agree upon the type of information the PEB should use to determine fitness and disability ratings. The small group of DES experts should also determine, across the military departments, a consistent period of time to make an election following a Physical Evaluation Board decision or explain how differences would still allow for due process.

To summarize the Assistant Secretary of Defense Decisions intervention:

- The ASD/FMP, direct the Director, Officer, and Enlisted Personnel Management to consult with a small group of experienced DES experts representing the military departments' PEBs and the Office of the Surgeons General to produce recommendations upon which the ASD/FMP, in coordination with the ASD/HA and the ASD/RA, can *decide* upon

- a statement of the purpose and the DoD's desired outcomes of the DES
- a statement of the purpose of the Medical Evaluation Board within the overall process
- appropriate time frames for initiating Medical Evaluation Boards
- appropriate standards for referring medical boards to the PEB
- mechanisms for seamless transmission of medical board information from one military department to another
- appropriate standards for determining fitness
- the information the PEB should use to determine fitness and disability rating
- a consistent period of time among the services to allow for service member election of options following a PEB (or higher-level appellate review board) decision.

Policy Guidance Intervention

The policy guidance intervention focuses on two types of actions: (1) formalization of the ASD decisions recommended in the preceding section and (2) specific OSD direction to require the military departments to use expanded certification as a means of ensuring a common understanding throughout the DES.

DoD Directive 1332.18 and DoD Instruction 1332.38 address the following issues, yet numerous primary participants identified the issues as ongoing problems that cause confusion and frustration. Therefore, with regard to the first type of action, we recommend that the OSD formalize the ASD decisions through reissuance of DoD Directive 1332.18 (1996) and DoD Instruction 1332.38 (1996). The DoD Directive should incorporate a clearly stated purpose of both the DES and the Medical Evaluation Board within the larger system. The DoD Instruction 1332.38 should set forth

- an appropriate time frame for initiating Medical Evaluation Boards
- clearly stated standards for referring medical boards to a PEB

- clearly stated standards for determining fitness, including explicit guidance regarding the role of nondeployability
- the information the PEB should use to determine fitness and disability ratings
- a definition of a consistent period of time for service members to elect options following a PEB or higher-level appellate board decision.

The DoD Instruction 1332.38 should also clearly set forth stated standards for the medical board format and the minimum information needed for the seamless transmission of medical boards from one military department to the PEB of another.

In addition, the military departments should expeditiously incorporate these changes into (1) their instructions and regulations; (2) the existing training programs and those that we propose in this report; and (3) the information sources available to all primary participants.

With regard to the second type of action, we recommend inserting a broader requirement for certification than the requirement contained in DoD Directive 1332.18 today. The current DoD Directive requires that the Secretaries of the military departments "ensure that physicians who serve on MEBs [medical boards] are *trained* in the preparation of MEBs [Medical Evaluation Boards] for physical disability evaluation." The DoD Directive also requires the Secretaries to ensure that PEB members and applicable review authorities are *trained and certified* in disability evaluation. We found no mechanism within the military departments on which the Secretaries could rely in order to ascertain whether they were, in fact, carrying out this direction. Certification is an excellent means of ensuring that appropriate training has been conducted and appropriate information sources have been used. It is an effective means of ensuring shared understanding of the DES purpose and desired outcomes, performance time frames, and performance standards throughout the DES.

We recommend certification for the following primary participants: (1) PEBLOs and disability evaluation counselors; (2) patient administrators who support the DES on a regular basis; (3) Medical Evaluation Board approving authorities; (4) PEB members, approving authorities, and administrative action officers; (5) physicians who write narrative summaries and specialty consultations, and those who serve on Medical Evaluation Boards; and (6) unit commanders. In particular, we recommend "self-certification" for physicians who write narrative summaries and specialty consultations and those who serve on Medical Evaluation Boards, as well as unit commanders. For example, the medical board should contain a statement signed by the contributing physicians that certifies they relied on available training and information sources in preparing their input. Likewise, the commander's letter should indicate whether the commander used available training and information resources in developing his or her input. This information should be collected as data in the management information system.

Consequently, the OSD should strengthen and expand leadership direction in the DoDD 1332.18 and DoDI 1332.38. In particular, we recommend that the DoD Directive require training and certification for (1) PEBLOs and disability evaluation

counselors; (2) patient administrators who support the DES on a regular basis; (3) Medical Evaluation Board approving authorities; (4) PEB members, approving authorities, and administrative action officers; (5) physicians who write narrative summaries and specialty consultations, and those who serve on Medical Evaluation Boards; and (6) unit commanders who submit commander's letters.

The requirements for supporting certification are discussed briefly later in this chapter and in greater detail in Chapter 5. Chapter 6 highlights the need for the recommended management information system to collect data on the certification status of primary participants as a key measure of system performance.

To summarize the Policy Guidance intervention:

- The OSD—formalize the decisions listed in the previous section through reissuance of DoD Directive 1332.18 and DoD Instruction 1332.38.
- The DoD Directive—require expanded use of certification as a means of ensuring a common understanding throughout the DES; for example, training and certifying physicians who dictate narrative summaries and write specialty consults, unit commanders who submit a commander's letter,[6] and PEBLOs, as well as Medical Evaluation Board approving authorities and PEB members, approving authorities, and administrative action officers.

Organizational Change Intervention

We recommend two fundamental organizational changes that would cut across the DES: (1) designation of a process owner for each military department DES and (2) establishment of an oversight committee at the Deputy Assistant Secretary of Defense level to assess system performance and expeditiously resolve issues that the Disability Advisory Council cannot.

A number of primary participants frequently cited the interface between the Medical Evaluation Board and the PEB as a particular problem source. Those charged with carrying out the medical evaluation phase perceive the PEB to be undervaluing the medical assessment of the service member's ability to perform his or her duties. Those charged with carrying out the physical evaluation phase perceive the physicians to be providing incomplete or inaccurate information upon which the PEB must make its determinations. Both perceptions are correct.

We recommend specific actions in other categories of interventions that will ameliorate many of the current problems. However, a more fundamental problem results from a lack of accountability for the overall process, which currently resides only at the level of Secretary. As a result, we recommend that the Secretaries of the military departments designate a process owner who is responsible for oversight and

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[6]Unit commanders must sign a document that describes the impact of the service member's medical condition on the member's ability to perform his or her normal military duties and to deploy or mobilize, as applicable. This document is commonly referred to as the "commander's letter."

control of the overall operation of the DES and is accountable for all outcomes within each military department's DES.

Within the OSD, as opposed to the individual military departments, oversight for the DES resides with the Under Secretary of Defense for Personnel and Readiness, who is the overall process "owner." However, no formal forum exists beyond the Disability Advisory Council,[7] which is composed of O-5s, O-6s, and GS-15s, to provide oversight of the DES, to examine problems and make decisions that the Disability Advisory Council cannot efficiently resolve because of the composition (organizational level) of its membership, and to evaluate overall DES performance.

We recommend that the Under Secretary form a standing committee—to be called a Disability Evaluation Committee—at the Deputy Assistant Secretary of Defense level. Membership should include the Deputy Assistant Secretary of Defense for Military Personnel Policy (the chair), the appropriate Deputy Assistant Secretaries representing the Assistant Secretaries for Health Affairs and Reserve Affairs, and an appropriate Deputy Assistant Secretary from each military department.

The current Disability Advisory Council would bring unresolved issues to the Disability Evaluation Committee during quarterly or biennial meetings.[8] In addition, the committee should review and evaluate, at least annually, information from the management information system, which is discussed again later in this chapter and described more fully in Chapter 6. The committee should direct DES actions to the Disability Advisory Council and the military departments, as appropriate, based on its analysis of that information. More importantly, establishing a Disability Evaluation Committee will raise the visibility of the DES within the DoD.

To summarize the Organizational Change intervention:

- The Secretary of each military department—designate a process owner[9] for the department's DES.

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[7]According to the Disability Advisory Council charter, April 28, 1998, "The Disability Council will be chaired by the Office of the deputy Assistant Secretary of Defense MPP (Officer and Enlisted Personnel Management) Director or their designee. The Assistant Secretaries of Defense (Health Affairs) and (Reserve Affairs) will nominate representatives to serve on the Disability Council. The Secretaries of the Military Departments shall also appoint representatives. The specific representatives may be chosen at the discretion of the Secretaries of the Military Departments. Normally, the Secretary of the Army shall appoint the Deputy Commander, U.S. Army Physical Disability Agency, and a representative of the Office of the Army Surgeon General. Normally, the Secretary of the Navy shall appoint the Director, Naval Council of Personnel Boards, and a member of the Office of the Chief of the Bureau of Medicine and Surgery. Normally, the Secretary of the Air Force shall appoint the Chief, USAF [U.S. Air Force] Disability Division, and a representative of the Office of the Air Force Surgeon General. The Office of General Counsel, Department of Defense, shall designate the legal advisor to the Disability Council. *The Secretary of the Department of Veterans Affairs shall provide representation from the Office of the Under Secretary for Benefits* [sic]."

[8]The structure could be modeled on the DoD's Per Diem, Travel, and Transportation Allowance Committee (PDTTAC), which is composed of membership at the Deputy Assistant Secretary level and supported by a military and civilian advisory panel at the field grade and civilian-equivalent level. We do *not* recommend, however, the addition of any staff for the Disability Advisory Council (other than the personnel that currently serve), as suggested by the PDTTAC model.

[9]A *process owner* is an individual or team designated for oversight of, control of, and accountability for all activities constituting a complete process—in this case, each military department's DES.

- The Under Secretary of Defense for Personnel and Readiness—establish a senior leadership oversight committee at the Deputy Assistant Secretary of Defense level to assess system performance and to resolve issues that the Disability Advisory Council cannot resolve expeditiously.

Personnel Policy Intervention

We recommend personnel policy intervention in two areas: (1) personnel policies that directly affect personnel in the DES and (2) personnel policies that potentially affect how primary participants in the DES make their decisions.

Regarding the first intervention area, the process owners (as recommended in the previous section) need not actually control all the resources of the military department DES. However, if they do not, we recommend that they nevertheless assess the performance of the military department PEB approving authority and the MTF commanders. The process owners should provide their assessment to the official who writes individual performance evaluations for the PEB approving authorities and the MTF commanders. The individual performance assessment should be based largely on the information that is gathered and reported by the management information system operator.

Regarding the second intervention area, two related personnel policies have the potential to introduce unwarranted variation into PEB decisions regarding fitness and/or disability ratings:

(1) Some primary participants we interviewed say that some PEBs "adjust" the fitness or disability ratings of a service member with a relatively minor, but unfitting disability who is nearing 20 years of service in order to allow the service member to retire for years of service. In a case like this, the "adjustment" might consist of designating what would normally be an unfit determination as a fit determination and returning the service member to active duty so that the member can go ahead and retire for years of service. An adjustment might also consist of raising a disability rating that would normally be 10 or 20 percent to 30 percent, thereby allowing the member to retire for disability (and draw disability retirement compensation) rather than separate for disability (with no disability compensation). We recommend that the OSD articulate an explicit policy regarding service members in this situation.

Strong cultural incentives exist to take care of fellow service members. Other personnel policies potentially contribute to the pressure to find nondeployable service members unfit, although DoD Instruction 1332.38 limits the extent to which the PEB can use nondeployability as the sole basis for unfitness. We recommend the services assess the possibility of placing service members who are fit but not deployable into units that can utilize their skills and experience without unduly hampering unit effectiveness and the effective operation of the service personnel system. The assessment should be conducted with a view toward ensuring the best use of trained resources.

(2) The Defense Authorization Act of 1993 amended 10 U.S.C. 1142 to require that service members receive pre-separation counseling no later than 90 days prior to separation. We found indications that the military departments direct members to begin pre-separation counseling before a fitness determination has been rendered, in compliance with the Defense Authorization Act of 1993.

Referral for pre-separation counseling sends a pretty strong message that a service member will likely be separated or retired and potentially creates false expectations on the part of the service member when in fact that service member may be found fit and subsequently returned to duty. Specific OSD guidance is needed to correctly interpret application of this statute in regard to service members undergoing disability evaluation. We recommend that the Office of the ASD/FMP review the impact of the Defense Authorization Act of 1993 amendment to 10 U.S. Code 1142 as it applies to service members undergoing disability evaluation and articulate an explicit policy regarding service members in this situation.

To summarize the Personnel Policy intervention:

- Process owners—assess the performance of the military department PEB approving authority and MTF commanders.
- The services—assess the difficulty of placing service members who are fit but not deployable into units that can utilize their skills and experience
- The OSD—articulate an explicit policy with regard to fitness and disability ratings for a service member who is nearing 20 years of service.
- The OSD—review the impact of the Defense Authorization Act of 1993 amendment to 10 U.S.C. 1142 that requires providing pre-separation counseling for service members no later than 90 days before separation, as it applies to service members undergoing disability evaluation.

Personnel Management Intervention

Many dedicated and capable people staff the various positions within the DES. Many of the primary participants that we interviewed acknowledge that the DES does not receive top priority in terms of selecting and assigning people with the competencies and experience who best match the job requirements. The DES is not, unfortunately, considered a career-enhancing assignment for many military personnel. Nevertheless, increased experience generally leads to better performance. Consequently, we recommend that the services review personnel policies with the objective of increasing PEBLO performance competencies, in particular, through a combination of experience and training.

Our observation of junior noncommissioned officers and petty officers serving as PEBLOs heightened our concerns that the level of maturity needed for the tough job of counseling required in these assignments may be lacking. As a result, we recommend that the military departments monitor the grades of individuals assigned as PEBLOs and disability evaluation counselors and notify the OSD when service mem-

bers below the pay grade of E-6 are assigned to these positions, and the military department's rationale for the assignment.

In addition, PEB leadership is critically important to the successful overall operation of the DES. Consequently, we recommend that the PEB approving authorities serve for a minimum of five years.

To summarize the Personnel Management intervention:

- The services—review personnel policies with the objective of increasing PEBLO performance capabilities through a combination of experience and training.
- The services—monitor the grades of individuals assigned as PEBLOs and disability evaluation counselors, and notify the OSD when service members below the pay grade of E-6 are assigned to these positions, together with the rationale for the assignment.
- The military departments—assign PEB approving authorities for a minimum of five years.

Training Intervention

As discussed throughout this report, this study was chartered to produce recommended changes to the training provided to primary participants of the DES to ensure more-consistent application of disability policy across and within military departments. This section presents the results of our issues-driven training needs assessment, which suggests that three major actions need to be taken to move toward more-consistent application of disability policy:

1. The Office of the ASD/FMP—develop and deliver training designed to expedite medical board processing.
2. The Disability Advisory Council—sponsor annual symposia for representatives of all primary participant populations across military departments.
3. The military departments—conduct annual symposia for primary participants within the departments.

The PEBLO training provided by all three military departments identified the same set of obstacles (which we call issues) to efficient processing of medical boards through the DES, and focused on resolving those issues. Likewise, independent interviews with numerous diverse primary participants identified the same set of issues and produced recommended training content that could be used in all the military departments to resolve those issues and result in more-consistent application of disability policy. The primary participants identified the following priority training content to resolve the issues:

- Template for narrative summary (contents and format)
- Medical board contents
- Required medical data in sufficient detail to enable cases to be adjudicated

- Documentation of rationale supporting Medical Evaluation Board decisions
- Commander's letter/nonmedical assessment
- Documentation of rationale supporting PEB decisions
- Differences between DoD and VA disability systems.

Table 4.1 presents the training content, including subcategories, by primary participant populations, as identified by primary participants who were interviewed. The full range of information for some topics appears in italics under those topics. The comprehensive training recommendation presented in Chapter 5 includes the training content and targeted primary participant populations listed in Table 4.1, with the exception of the service member population.[10] The next section of this chapter presents a recommended action to address the issue of service members' confusion in distinguishing between VA and DoD disability systems.

Throughout this study, we perceived that the primary DES participants do not necessarily think of themselves as part of a *system* or that what they do is part of a *process.* Although a segment of the training content recommended in Chapter 5 focuses on participants developing a broad perspective of their role within the overall DES—that is, a system perspective—periodic workshops or symposia could augment formal training. When conducted with the specific objective of enhancing communication to produce more-consistent application of disability policy, workshops can be a powerful training delivery method for fostering a broader system perspective.

Consequently, we recommend that the Disability Advisory Council sponsor an annual cross-military department symposium at which representatives of all appropriate primary participant populations can present, review, and analyze military department data; propose corrective actions; and identify best practices. Periodic attendance at these symposia should be a requirement for continued primary participant certification.

We also recommend that the military departments conduct annual symposia at which department primary participants present, review, and analyze service data; propose corrective actions; and identify best practices.

To summarize the Training intervention:

- The OSD/FMP—develop and deliver training designed to expedite medical board processing.
- The Disability Advisory Council—sponsor an annual cross-service symposium.
- The military departments—conduct annual symposia for all primary participant populations in the DES to present, review, and analyze military department data; propose corrective actions; and identify best practices.

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[10]Primary participants noted that many congressional inquiries result from service members not understanding the difference between the DoD Disability Evaluation System and the Department of Veterans Affairs Disability Compensation System and therefore believing they have been treated unfairly.

Table 4.1

Primary Participant Training Needs Derived from Issues-Based Analysis

Training Content	PEBLOs/ Disability Evaluation Coun-selors	Patient Adminis-trators	PEB Adminis-trative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members/ Approving Authorities	PEB Members/ Approving Authorities	Appellate Review Board Members	Attorneys Who Represent Service Members	Active Compo-nent Unit Com-manders	Reserve Compo-nent Com-manders	Service Members
Narrative Summary Template (contents and format)	X	X		X	X						
Contents of Medical Board											
Narrative summaries containing sufficient detailed information for PEB adjudication	X	X		X	X						
Appropriate specialty consultations	X	X		X	X						
LOD Determinations (Notice of Eligibility for Navy Reserves)	X								X		
Complete physical examination (Standard Form 88/93)	X	X		X	X						
Comprehensive Clinical Evaluation Protocol (CCEP) data	X	X		X	X						
Documents dated within the past 90 days	X	X		X	X						
Appropriate signatures	X	X			X						

Table 4.1—Continued

Training Content	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members/ Approving Authorities	PEB Members/ Approving Authorities	Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders	Service Members
Necessary Medical Data in Sufficient Detail to Adjudicate Cases											
Orthopedic cases (in particular, backs)	X	X		X	X						
Neurological/neurosurgery cases (in particular, backs)	X	X		X	X						
Ophthalmologic cases	X	X		X	X						
Pulmonary cases	X	X		X	X						
Cardiological cases	X	X		X	X						
Psychiatric cases (e.g., epilepsy, narcolepsy)	X	X		X	X						
Migraine headache–related cases	X	X		X	X						
When Specialty Consultations and Details Are Required											
Fibromyalogic cases	X	X		X	X						
Chronic Fatigue Syndrome cases	X	X		X	X						
Gulf War Syndrome/ Southwest Asia theater of operations–related CCEP	X	X		X	X						
Psychiatric diagnoses/ neuropsychological testing for head injury patients	X	X		X	X						
HIV cases	X	X		X	X						

Table 4.1—Continued

Training Content	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members/ Approving Authorities	PEB Members/ Approving Authorities	Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders	Service Members
Documentation of rationale supporting Medical Evaluation Board decision	X				X						
Commander's Letter or Nonmedical Assessment											
Timely response	X								X		
Judgment regarding how condition impacts service member's ability to perform duties	X								X		
Judgment regarding service member's ability to deploy	X								X		
Adverse actions pending	X								X		
Documentation of rationale supporting PEB decision	X					X					
Difference between VA and DoD Disability Evaluation Systems	X										X

Information Source Development Intervention

The information source intervention focuses on three types of OSD actions: (1) development of up-to-date and readily available information banks shared by the military departments; (2) creation of a virtual communications network for the primary participants; and (3) creation of an instrument for conducting customer surveys. With regard to the first action, see Chapter 5 for a description of our recommendation that the OSD devote a Web site to self-directed computer-based distance training for disability evaluation.

We envision the training packages including comprehensive samples of the documents required to process a case through the DES. In particular, the unit commanders' training package should contain examples of well-written and effective commander's letters. Ideally, the unit commander should use a Web-based template for on-line transmission to the PEBLO or patient administrator handling a specific case. In addition, the unit commanders' training package should provide all the information commanders must have regarding the need for and preparation of a LOD determination, including examples of LOD determinations. The unit commanders must also have a means of transmitting the information electronically.

Likewise, we envision a similar Web-based information source that provides a training package for physicians. In particular, the physicians' training package that would be accessed from the proposed Web site should include examples of well-written and effective narrative summaries and specialty consults. Ideally, a physician would access an electronic template to write narrative summaries and provide specialty consult input.

The electronic format is intended as a user-friendly guide to narrative summary requirements (such as tests and measures required for a complete medical board) for all diseases and injuries in general and the five specialties that make up the majority of consults in particular. The electronic format overcomes a problem we identified: Unlike paper documents, it is an information source that physicians cannot take with them when they rotate to a new assignment, so it will be there for the next physician who needs the training. This format also invites interaction because it is physically available and current, it makes physicians' jobs easier, and because physicians know it makes their jobs easier, they will come to rely on it.

If the OSD does not develop the recommended self-directed computer-based distance training, it should incorporate the information described earlier pertaining to the unit commanders' and physicians' training into the medical instructions or directives pertaining to the Medical Evaluation Board. The Office of the Surgeons General should update the medical policy documents to match the OSD and military departments' disability policy documents, and describe the appropriate format and content of medical boards.

To supplement the training packages for PEBLOs/disability evaluation counselors and patient administrators, we recommend organizing structured information in a centralized location on a Web site for frequent updating. The Web site should contain DoD and military department directives, instructions, and regulations; contact

information for cohorts and centrally located experts; frequently asked questions and their answers; and other up-to-date information.

As part of this centrally located Web site information source, or as a separate source, we recommend that the OSD provide individual service members access to all the information they need to understand the DES and their rights and entitlements under it, through either a Web site and/or a published document. In particular, this Web or print document should include a comprehensive comparison of the DoD Disability Evaluation System and the VA Disability System. The material developed for the proposed computer-based distance-training packages (described in Chapter 5) can serve as the basis for developing this information source, which could also contain answers to frequently asked questions.

We also recommend that the OSD develop a database of DES best practices. The database should contain data collected from the recommended workshops and symposia suggested earlier in this chapter and from the virtual communications network we recommend next.

With regard to the virtual communications network, we recommend that the OSD establish a separate mailing list server[11] for the Medical Evaluation Board approving authorities, another for the PEB members and approving authorities, and lastly, one for the PEBLOs. A list server offers an effective means of bringing consistency to disability policy application, particularly to cases that arise infrequently. Because the Army and Navy PEBs are geographically dispersed, they especially would benefit from it. Each primary participant population's list server should include all the military departments in order to share the greatest amount of information. As in the case of the Medical Evaluation Board approving authorities and the PEB members and approving authorities, a list server for PEBLOs serves as a mechanism for soliciting advice from the entire PEBLO knowledge base.

With regard to the third information source development action—creation of an instrument for conducting customer surveys—we recommend that the OSD develop a survey instrument to measure customer satisfaction, which the services would administer to every service member who has contact with the DES, including those who are returned to duty. A survey of satisfaction is, admittedly, a lagging indicator of DES performance. Nevertheless, it is an important measure of system outcomes. To "get ahead of the system" (that is, to measure the determinants of customer satisfaction before customer satisfaction is negatively affected), we propose a comprehensive management information system, which is discussed next. The customer satisfaction survey is an important component of such a management information system.

To summarize the Information Source Development intervention:

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[11]According to www.pcwebopaedia.com, a list server is a "server that manages mailing lists for groups of users." Two of the most popular e-mail mailing list server systems for the Internet are LISTSERV and Majordomo.

- The OSD—produce electronic media that include a comprehensive sample of the documents needed to process a case through the DES, together with easy-to-use reference documents.
- The OSD—develop a brochure and/or Web site for individuals separated or retired for disability that describes the service member's rights, benefits, and entitlements and the significance and consequences of the determinations reached, including a comprehensive comparison of VA and DoD disability systems.
- The OSD—develop and maintain a database of "best practices" in the DES.
- The OSD—establish a list server for Medical Evaluation Board approving authorities, another for PEB members and PEB approving authorities, and another for PEBLOs.
- The OSD—develop a survey instrument to measure customer satisfaction that the military departments administer to every service member who has contact with the DES, including those returned to duty.

Management Information System Deployment Intervention

Currently, no central structured mechanism exists to gather data across military departments to inform actions or assess how well the DES accomplishes its intended purpose and desired outcomes. A comprehensive management information system with this data-gathering capability would be a key intervention enabling the Under Secretary of Defense for Personnel and Readiness, the Assistant Secretaries of Defense, and the Secretaries of the military departments to carry out their responsibilities under DoD Directive 1332.18. A system capable of monitoring key performance measures in the DES would also provide the necessary foundation for an institutional mechanism for quality control and quality assurance.[12]

Therefore, we recommend that the ASD/FMP, after consulting on the information needs of the ASD/HA and ASD/RA, direct the Director, Officer and Enlisted Personnel Management, to develop and maintain a comprehensive management information system capable of monitoring DES performance measures (as they apply to active and Reserve components). Chapter 6 describes such a system in more depth.

Based on the issues we observed in the medical evaluation phase of the DES, the MTF commanders and the Surgeons General need information from a management information system such as the one being proposed. The MTF commander should review data at their most disaggregated level. In particular, the commander should examine reports on medical boards returned by the PEB—for insufficient data or for any other reason—broken out by reason for return, referring physician, PEBLO, and unit commander. The Surgeon General should review a more-aggregate form of the

[12]Chapter 3 describes, within the context of the overall DES operating framework, the existing measures the OSD requires the military departments to report.

data to determine if particular MTFs stand out, either as performance benchmarks or problem areas, with a focus on the timeliness of Medical Evaluation Boards.

To provide these aggregated and disaggregated reports, the management information system should be capable of tracking medical boards from dictation of the narrative summary to the signature of the MTF commander. The form of the reports can vary among the military departments provided they track individual medical boards and can summarize the total elapsed time from dictation of the narrative summary to the commander's sign-off.

In addition, as noted earlier, DoD Directive 1332.18 holds the Secretaries of the military departments accountable for ensuring that physicians are trained and that PEB members are trained and certified. Certification is a key output measure[13] for monitoring system performance. In order for the Secretaries to carry out these responsibilities, we recommend that the management information system operator report on the certification status of the primary participants of the DES (we recommend some additional certification requirements in the earlier section on policy guidance interventions).

To summarize the Management Information System Deployment intervention:

- The ASD/FMP, after consulting on the information needs of the ASD/HA and the ASD/RA—direct the Director, Officer and Enlisted Personnel Management, to develop and maintain a comprehensive management information system capable of monitoring DES performance measures (as they apply to active and Reserve components).
- Management information system operator—provide reports to MTF commanders and the Surgeons General on the status of medical boards in enough detail to identify bottlenecks and to highlight "best practices."
- Management information system operator—provide the Secretaries of the military departments reports on the certification status of primary participants.

Process Intervention

Process[14] changes, by their very nature, interact with changes in the other categories of interventions. As a result, several actions constituting the process intervention link to actions in other interventions.

We recommend that the OSD direct the military departments to implement a procedure whereby a Medical Evaluation Board, upon deciding to forward a case to the PEB, would trigger a letter from the MTF commander to the unit commander. The letter should state the intent to process the service member through the DES. It

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[13]*Output measures* assess immediate performance results of key parts of the system that contribute to system outcomes. They are a mix of lagging and leading indicators of performance.

[14]The term *process*, as used here, is a particular method of operating the DES involving a number of steps or operations. Other categories of interventions have focused on actions within those specific steps or operations.

should by and large be a form letter, ideally in electronic format, that details the DES process and explains that processing of the case and replacement of the service member cannot occur without the commander's letter and the LOD determination. The letter should also refer the unit commander to the proposed unit commander training package located on the proposed DoD disability evaluation Web site. The letter should also identify the responsible PEBLO.

One practice we became aware of during the course of our interviews seems to lend greater expertise to the writing of narrative summaries and could have wider application. Some MTFs designate and train one physician (or several depending on the workload) at each facility to write all narrative summaries. Alternatively, some MTFs employ retired physicians to carry out this function. We recommend that the military departments explore these practices in greater depth for possible wider applicability.

Several sources suggested that cases become "lost" while awaiting the compilation of specialty consults. The Air Force assigns responsibility to the initial contact physician to ensure that the case proceeds through the appropriate consultations. In effect, the Air Force designates a "case owner." We recommend that the other military departments assess the Air Force process in terms of its applicability to their own departments. In addition, the departments should consider other alternatives, such as assigning a case to a PEBLO or patient administrator as soon as an attending physician determines that the service member likely will require fitness evaluation for retention in a duty status.

In order to use the data generated by a management information system effectively, the data must be gathered, evaluated, and acted upon. With the exception of the Army, we found little organizational capability to use information to improve system operation. We recommend that each military department develop an organizational capability that would enable it to use data to improve system operation. This capability could reside at the PEB or, as in the case of the Army, in an oversight organization. If the recommendation to appoint a process owner in each military department is adopted, the capability should reside with that individual. Wherever the capability resides, it should be the basis for information presented to senior officials responsible for system oversight.[15] The OSD should develop a similar capability to evaluate the data across military departments and components.

To summarize the Process intervention:

- The OSD—direct the military departments to implement a procedure whereby a Medical Evaluation Board deciding to forward a case to the PEB triggers a letter from the MTF commander to the unit commander explaining the unit commander's role in the process.
- The military departments—explore existing practices for designating physicians with expertise in writing narrative summaries for wider applicability.

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[15]A proposed capability such as this would help ensure consistent policy application within the military department and would help facilitate the generating and monitoring of reports, such as comparisons of dispositions between officers and enlisted members among various career fields and between active and Reserve components.

- The other two military departments—assess for applicability the Air Force process of assigning to the initial contact physician responsibility for ensuring a case proceeds through the appropriate consultations to narrative summary dictation in a timely manner.
- Each military department—develop an organizational capability to use data from the management information system to improve system operation.

Incentives Intervention

To give military treatment facilities a greater incentive to assure that medical boards from the Medical Evaluation Board are sufficient before passing them to the PEB, we recommend that each PEB publicly recognize each year's best-performing MTF by presenting an award of excellence. This award would be based, for example, on the percentage of medical boards deemed "sufficient for adjudication" by the PEB.

Although this recommendation applies to only one phase of the disability evaluation process (based on the issues identified during the goal fabric analysis), similar formal and informal awards presented for top performance in all phases of the DES could contribute to smoother operation of the system as a whole. Deployment of the recommended management information system would ensure that reliable data is available to serve as the basis for selecting high performers for these awards.

To summarize the Incentives intervention:

- Each PEB—publicly recognize the best-performing MTF annually with an award of excellence; similar formal and informal awards throughout the system contribute to smoother overall system operation.

A PARADIGM SHIFT: FROM ENSURING CONSISTENT POLICY APPLICATION TO IMPROVING SYSTEM PERFORMANCE

The focus of this chapter so far has been on issues regarding the consistent application of disability policy and proposed actions to facilitate consistent policy application based on our bottom-up goal fabric analysis. Although consistent application is an important aspect of system performance, it does not represent the whole picture.

All ten interventions listed earlier in this chapter are necessary to achieve more-consistent application of disability policy. Two interventions in particular, however, merit more-extensive development than the other interventions because of their greater impact on improving system performance: DES primary participant training and implementation of a management information system. In order to develop the most effective training program and management information system—interventions intended to improve system performance over time—a different approach or methodology is needed in contrast to the issues-driven, bottom-up approach used to develop the interventions proposed in this chapter.

Identifying interventions to improve DES performance ideally requires a "top-down" methodology. Such an approach first requires a commonly agreed upon stated purpose for the DES, then a desired set of system outcomes, and finally, for a truly effective training intervention, a management information system to measure actual outcomes against desired outcomes. In this context, the differences between desired and actual outcomes lead to the identification and recommendation of DES primary participant training and other interventions to eliminate the differences. Figure 4.2 illustrates such a top-down, purpose-driven methodology.

This methodology begins with a clearly articulated statement of the purpose of the DES. The desired system outcomes describe what successful system performance would look like. Although desired outcomes are unlikely to be achieved quickly or easily because they portray the *ideal* system results that matter to customers—that is, they "stretch" the organization—they establish the basis for performance targets to guide individual and collective actions, in this case, the basis for identifying and assessing interventions.

Unfortunately, the foundation for developing these interventions—that is, a stated purpose for the DES and identification of desired outcomes, which are needed to employ this approach—are not available today with respect to DES. That, in addition to the absence of a management information system capable of monitoring system

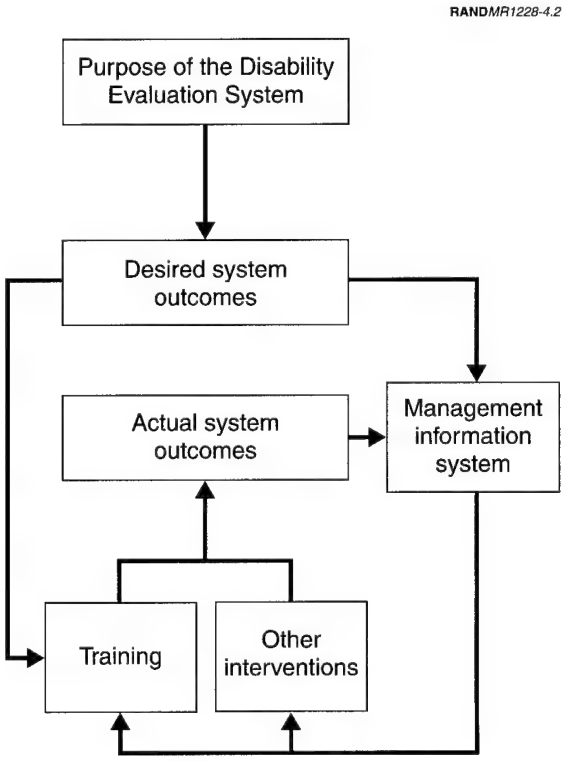

Figure 4.2—Ideal Methodology for Identifying Interventions for Improved System Performance

performance across military departments, was the primary reason we did not employ the top-down methodology in this chapter.

The desired outcomes suggest the sort of data the management information system operator needs to gather, and the competencies that the primary participants require to perform their assignments effectively. By comparing actual outcomes with desired outcomes, the management information system facilitates development of training and other interventions.

Nevertheless, to develop the training intervention and specifications for a management information system that can eventually assess the effectiveness of training and other interventions, we demonstrate later in this report the top-down methodology based on the purpose and outcomes suggested in Chapter 3. Chapter 5 describes the training intervention in detail and Chapter 6 describes the structure of a management information system. A comparison of the two analytic methods (the bottom-up, issues-driven goal fabric method and top-down, purpose-driven method) can be found in Appendix F.

Chapter Five

DISABILITY EVALUATION SYSTEM TRAINING ANALYSIS AND RECOMMENDED CHANGES IN TRAINING TO IMPROVE SYSTEM PERFORMANCE

This chapter presents an extensive top-down, purpose-driven training needs analysis to establish the recommended content and delivery method for DoD disability evaluation training. The recommended training content is designed to enable primary participants to develop the proposed performance competencies, which are based on the set of desired outcomes and the DES purpose statement we propose in Chapter 3. This chapter begins by introducing the methodology used and bodies of DES-specific knowledge, and then summarizes existing training activities. This chapter also identifies and segments the target training populations and suggests primary participant performance competencies based on the stated purpose of the DES and the desired system outcomes as proposed in Chapter 3.

This chapter also identifies the DES topics that constitute the training content. The DES topics are grouped by primary participant population clusters (including unit commanders and attorneys who interact with the system) that require the necessary knowledge to produce desired on-the-job results. Finally, this chapter examines other training design considerations and closes with a detailed discussion of the following recommendations for changes in training to ensure more-consistent application of disability policy across and within the military departments.

We recommend that the Office of the Assistant Secretary of Defense for Force Management Policy champion—that is, develop and monitor—knowledge-based training in which the content focuses on specific bodies of DES knowledge for primary participant population clusters across the military departments.

We further recommend delivering this knowledge-based training through a Web site devoted to disability evaluation training that can be accessed by all primary participants. This self-directed computer-based distance training is a basic course in disability evaluation, tailored to the needs of each primary participant population cluster. More-advanced classroom training, tailored to the needs of adjudicators and physicians, supplements the distance training. This training focuses on applying a particular set of DES topics to develop the skills necessary to evaluate and adjudicate cases consistently across and within the military departments—a primary determinant of consistent application of disability policy.

METHODOLOGY

Developing a comprehensive training intervention ideally begins with a needs assessment based on system performance. This assessment first requires an agreed-upon statement of organizational intent. In this particular case, it requires a purpose statement for the DES, together with a set of desired system outcomes and a management information system capable of monitoring and assessing how well the system accomplishes its overall purpose. Unfortunately, as noted earlier in this report, these prerequisites do not currently exist. Therefore, given our exposure to the issues presented by primary participants, our observation of current military department training events, and our study of policy documents, we formulated a DES purpose statement and a set of desired system outcomes, which are presented in Chapter 3, that serve as the basis for the training recommendations in this chapter.

We propose a specific purpose and set of desired outcomes in order to present a methodology for developing the training intervention and a set of metrics for use in a management information system. We formulated suggested performance competencies for each of the primary participant populations across the military departments to better focus our training needs assessment and recommendations.

However, based on our study, we believe the OSD should determine a DES statement of purpose and a set of desired outcomes, and then reapply the methodology to the purpose and desired outcomes that its leaders produce. Decisions on the purpose statement, the desired outcomes, and primary participant competencies inform the specific training content and training packages tailored to the needs of primary participant population clusters.

As noted in Chapter 4, we recommend that as a first step, the ASD/FMP direct the Director of Officer and Enlisted Personnel Management to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General, to produce recommendations upon which the ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide upon a statement of the purpose and DoD's desired outcomes of the DES. This statement of purpose and the desired outcomes, in turn, shape the performance competencies required by the primary participant populations and the specific training content, which ideally, emerges from additional group consultations.

This report presents an integrated methodology to serve as both a starting point and a guide for final determination of training content and delivery. This chapter, in particular, demonstrates this methodology using the DES purpose and desired system outcomes proposed in Chapter 3.

BODIES OF DES-SPECIFIC KNOWLEDGE

Executing DoD disability policy through the three military departments' Disability Evaluation Systems requires primary participants to interpret, at an operational level,

hundreds of specific requirements derived from various statutes[1] and policy documents. Assignment to positions within any of the first three phases of the DES—medical evaluation; physical disability evaluation, including both the Informal PEB and the Formal PEB; and appellate review at a level beyond the PEB[2]—requires specific bodies of knowledge and skills to interpret and apply disability policy—knowledge and skills generally not acquired in other assignments.

As a result, every person assigned to a position or designated for duty in any of these three phases of the DES requires a new body of knowledge based on a set of DES topics and new skills to produce the desired on-the-job results. Active and Reserve component unit commanders who interact with the system and attorneys who represent service members during appeals also require a new body of knowledge based on the DES topics.

Producing the desired on-the-job results also requires other abilities, characteristics, traits, and behaviors that individuals may acquire in other assignments, such as the ability to apply quality principles, operate automated systems, write clearly, collect and organize information according to a stated standard, and the ability to project a cooperative team spirit, professional image, and positive attitude within an office environment. This chapter focuses on the need for DES bodies of knowledge and skills.

We accept the premise that individuals who possess specific bodies of knowledge and skills related to their jobs in the DES are more likely to consistently apply disability policy. Therefore, we believe training that enables participants to produce the desired on-the-job results is a critical management intervention for ensuring consistent policy application.

Current Disability Evaluation Training Within the Department of Defense

The OSD currently provides no disability evaluation training; however, it does sponsor quarterly meetings for the senior leaders of the military departments' PEBs and the medical communities that compose the DES, the legal communities that interact with the system, and other interested parties.[3]

Currently, individuals assigned to positions within the first three phases of the DES, in addition to unit commanders who interact with the system, acquire knowledge on new DES topics and gain new skills primarily through ad hoc on-the-job training. In virtually all cases across the military departments, newly assigned individuals start performing their jobs immediately and learn new DES topics and skills bit by bit on a case-by-case basis. As described by primary participants during our interviews with

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[1]Those statutes include Section 104 of Title 26, U.S.C., Chapter 61, U.S.C., Sections 801–940 of Title 10, U.S.C.; Sections 3502, 5532, 6303, and 8332 of Title 5, U.S.C.; Sections 206 and 502 of Title 37, U.S.C.; and Sections 101 and 302 of Title 38, U.S.C.

[2]The DES is composed of four phases. The fourth phase is final disposition.

[3]See Footnote 8 in Chapter 4.

them, management seems to accept mistakes made in the course of learning and any inconsistencies in policy application that may result as a cost of doing business.

Each of the military departments' PEBs provides some classroom training targeted to its PEBLO population (ranging from one to two weeks on an annual or quarterly schedule), to which they invite other interested primary participants, including attorneys. The Army Physical Disability Agency is the only military department that develops and once a year or so conducts comprehensive classroom training. Although this training is targeted to the needs of Army adjudicators, the agency invites other primary participants and offers limited seats to adjudicators from the other military departments. The Air Force Disability Division convenes quarterly meetings for all Air Force Informal PEB and Formal PEB members, which are also attended by an appellate review board member. Meeting participants discuss cases, problem areas, and the process by which they make decisions. The Army established a list serve for PEBLOs, and the Department of the Navy provides a PEBLO training video.

PEB members, approving authorities, and administrative action officers in all three military departments take the initiative to share information with their respective department's medical community—the physicians who write narrative summaries and who serve as Medical Evaluation Board members and approving authorities—in person. PEB members, approving authorities, and administrative action officers visit a few of these physicians each year to provide training to help them prepare medical boards that are sufficiently detailed, timely, and complete for PEB adjudication.

At some military treatment facilities, patient administrators or the Medical Evaluation Board approving authorities advise physicians on how to dictate sufficiently detailed and complete narrative summaries and specialty consults. The various military treatment facilities handle physician training differently, and may range from personal mentoring to brown bag lunches to locally developed guidelines. For example, the President of the Department of the Navy PEB and the PEB administrative action officers present a half-day briefing to senior enlisted members during the Navy's course on patient affairs. Additional ideas for improving primary participant training and system performance are in various stages of development in all three military departments.

The PEB approving authorities[4] in all three military departments champion the DES. They continuously urge collaboration among primary participants and admonish their subordinates to "communicate, communicate, communicate." All of the military departments have also established some sort of information-sharing presence on the World Wide Web.

Clearly, the military departments collectively employ a wide range of training methods to enable primary participants to produce desired on-the-job results; on-the-job training; mentoring and coaching; self-directed learning, including videos and early-

[4]Those authorities include the Deputy Commander, Army Physical Disability Agency; President, Physical Evaluation Board (Department of the Navy); and Chief, Air Force Physical Disability Division.

stage computer-based distance training; seminars and workshops; and formal classroom training, including case studies. Lacking clear direction from the OSD, however, each military department conducts training to meet its own recognized needs based on its interpretation of policy with little regard for training to enhance the consistency of disability policy across the military departments.

Because the objective of this study was to identify and recommend changes to training provided to the primary participants of the DES, we began with the current training practices and then focused on recommended improvements. The first step in this process entails identifying the target population.

Target Population

Training is effective only to the degree that it produces the desired behavior[5] in the population trained. We identified 12 primary participant populations who require specific bodies of knowledge and skills to execute disability policy throughout the military departments:

1. Physical Evaluation Board liaison officers (PEBLOs), and disability evaluation counselors (in the Department of the Navy)
2. Patient administrators (who assist PEBLOs at military treatment facilities)
3. Physicians at MTFs (who write narrative summaries and specialty consults for medical boards)
4. Medical Evaluation Board members at MTFs
5. Medical Evaluation Board approving authorities at MTFs
6. Physical Evaluation Board administrative action officers (who quality check and process medical boards)
7. Physical Evaluation Board members
8. Physical Evaluation Board approving authorities[6]
9. Appellate review board members beyond the Formal PEB
10. Active component unit commanders (who interact with the DES)
11. Reserve component unit commanders (who interact with the DES)
12. Attorneys (who represent and advise service members).

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[5]*Desired behavior* has been defined as an action or response to a situation in which a performer uses certain knowledge and skills to bring about a desired result (Shapiro, 1995).

[6]These approving authorities include the Deputy Commander, Army Physical Disability Agency; President, Physical Evaluation Board (Department of the Navy); and Chief, Air Force Physical Disability Division.

Characteristics of Target Population. Predominant characteristics of the target training population impact training design. The distinguishing characteristics of the DES target training population include:

- Frequent turnover among many primary participants
- Dispersion of primary participants across the United States
- Wide variation of subject matter expertise among primary participant populations
- Wide variation in the amount of required disability evaluation detailed knowledge among different primary participant populations
- A high level of computer literacy and comfort with using computer systems.

Turnover Among Primary Participants. Most of the primary participant populations consist of military members and are, therefore, subject to frequent reassignment and relocation, often every two to three years. Whereas Departments of the Army and Navy physicians serve as Medical Evaluation Board members at virtually any time required, Department of the Air Force physicians generally serve on Medical Evaluation Boards on an ad hoc basis, rotating in and out of board duty during a normal assignment to an MTF.

Air Force PEBLOs generally rotate in and out of PEBLO duty during a two- to three-year tour to an MTF. Within the Army DES, some PEB physician members and most PEBLOs (assigned to CONUS) are Department of the Army civilians and therefore, turn over infrequently. Similarly, nine out of ten Air Force PEB action officers and some Department of the Navy disability evaluation counselors are military department civilians and therefore turn over infrequently. The military departments reported on approximate tour lengths among the primary participant populations, which are shown in Table 5.1.

Geographic Dispersion. Physicians are the most widely dispersed population because virtually any physician in an MTF may write a narrative summary. PEBLOs, patient administrators, and physicians who serve on Medical Evaluation Boards are also widely dispersed wherever military treatment facilities exist. As an example, Figure 5.1 illustrates dispersion of Department of the Navy PEBLOs and disability evaluation counselors.

PEB members, approving authorities, and administrative action officers are located at Randolph Air Force Base and Lackland Air Force Base, Texas; Fort Lewis, Washington; Fort Sam Houston, Texas; San Diego, California; Bethesda, Maryland; and Washington, D.C. Likewise, attorneys who represent service members during appeals are currently dispersed over the same locations as the formal PEBs. Active and Reserve component unit commanders who interact with the DES from potentially every military installation and deployment are the most dispersed populations.

Table 5.1

Approximate Tour Lengths of Primary Participants

Primary Participants	Department of the Army	Department of the Navy	Department of the Air Force
Physicians Who Write Narrative Summaries	3–4 years	3–4 years	Ad hoc duty during 3- to 4-year tour
PEBLOs	3 years (military, OCONUS) 2–20 years (civilian, CONUS)	3 years	Commonly rotate through PEBLO duty during 2- to 3-year tour at an MTF
Disability Evaluation Counselors	N/A	1–3 years (military) 3–15 years (civilian)	N/A
Patient Administrators	2–3 years	2–3 years	2 years
Medical Evaluation Board Members	2–3 years	2–3 years	Rotate physicians through Medical Evaluation Board duty during normal tour
Medical Evaluation Board Approving Authorities	2 years	2–3 years	2–3 years
PEB Administrative Action Officers	Civilian	1–3 years	Civilian
Physical Evaluation Board Members	1–2 years	1–3 years	3 years
Physical Evaluation Board Approving Authorities	1–2 years	6 months	1–2 years
Post-PEB Appellate Review Board Members	3 years	3 years	Ad hoc duty during 3-year tour
Attorneys	1–2 years	1–3 years	3–4 years
Unit Commanders	12–18 months	2–3 years	—

Subject Matter Expertise. All primary participants bring some level of expertise and specialty knowledge of certain subject matter to their positions within the DES. Physicians—generally interns and first-year residents—who write narrative summaries, as well as those who write specialty consults and those who serve on Medical Evaluation Boards and PEBs, bring extensive health care and medical expertise to the DES. Likewise, attorneys who advise service members, normally as their first assignment after completing law school, bring legal expertise to the DES.

Officers assigned as PEB approving authorities (O-6s), nonmedical members of the PEB (generally O-5s), and those who serve ad hoc on appellate review boards, all of whom are typically serving their last tour before retirement, bring their depth of expertise as senior military leaders from a variety of subject matter backgrounds.

Long-serving PEBLOs, patient administrators, and PEB administrative action officers bring expertise in their occupational specialties based on their years of experience. Department of the Navy military disability evaluation counselors and Air Force PEBLOs probably have the greatest variation in terms of the levels and range of subject matter expertise. Lastly, unit commanders, typically O-3s, bring unique command and varied subject matter expertise.

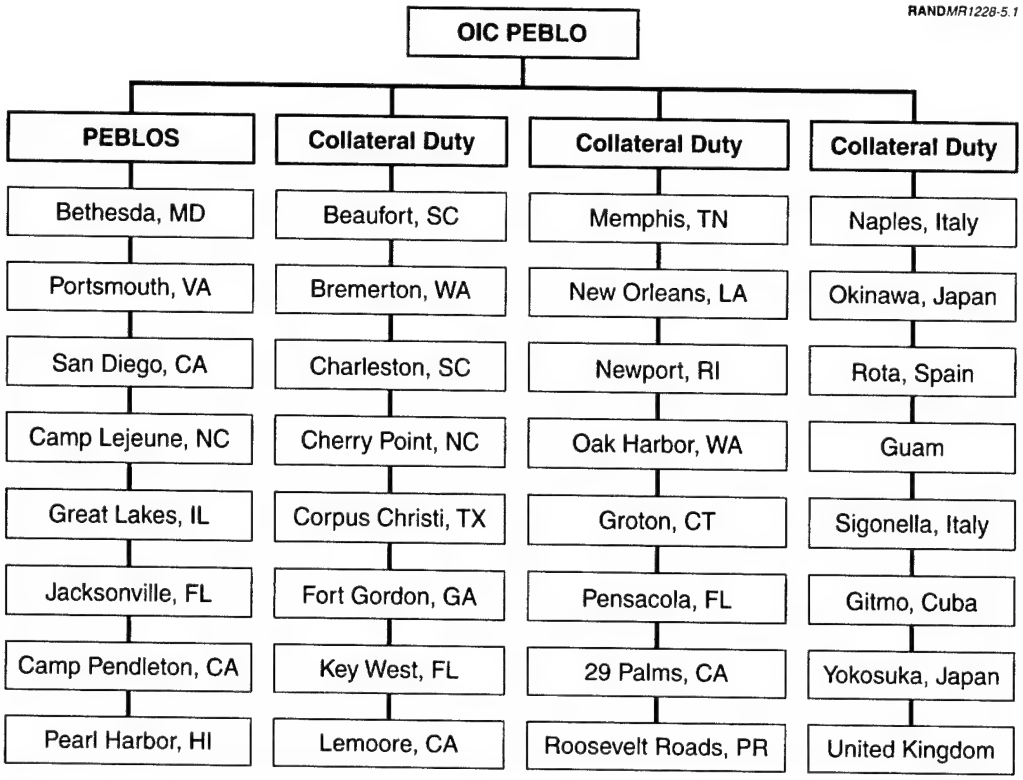

Figure 5.1—Example of Geographic Dispersion: Department of the Navy PEBLOs and Disability Evaluation Counselors with Collateral Duty

Noticeably, this vast range of subject matter expertise also reflects great diversity in educational backgrounds and learning experiences. But more significantly, few, if any, primary participants typically bring DES-specific subject matter expertise to their positions in the DES.

Variation in Level of Required Disability Evaluation Expertise. Although different primary participant populations require identical levels of understanding of many DES topics, such as the DES purpose and desired system outcomes, some require vastly different levels of detailed understanding in order to produce the desired results in their various jobs. For example, physicians who serve on PEBs require an in-depth understanding of how to apply VASRD codes to the wide range of medical diagnoses presented in medical boards and how to rate diagnoses by analogy.[7] Likewise, PEBLOs require sufficient understanding of how to apply VASRD codes and rating by analogy to explain to service members what it would take to warrant a different VASRD or analogy code. By contrast, patient administrators, PEB administrative action officers, and unit commanders, for example, only require a limited understanding of VASRD and analogous codes.

[7]When a medical condition is not listed in the VASRD, physicians who serve on the PEB may use a specific procedure to rate it under a closely related disease or injury in which not only the affected functions, but also the anatomical localization and symptomatology, are closely analogous.

Computer Literacy. Today's high-tech military relies heavily on computers and, as a result, produces a computer-literate workforce, both military and civilian. Individuals assigned to the DES generally possess computer skills.

These target training population characteristics appear again with the design considerations presented later in this chapter. The next section suggests performance competencies for primary participant populations across the military departments.

Competencies Derived from Desired Outcomes

Ideally, a training intervention is closely tied to the organization's job analysis and design, assignment, and individual performance management practices. Further, the intervention requires assessing the existing performance competencies including bodies of knowledge, skills, abilities, characteristics, traits, and behaviors exhibited by individuals assigned to the positions and then comparing their individual and group performance to a set of desired results and behaviors.

Job analysis,[8] the preferred technique to assess competencies, is time-consuming and beyond the scope of this project. It should be undertaken only after the OSD itself establishes a stated DES purpose and set of desired outcomes, which would serve as guidelines for the analysis. Ideally, developing training that produces desired behaviors and desired on-the-job results from the population trained requires the capability to monitor system performance and system results and compare them to a set of stated desired results. Chapter 6 describes a management information system that could serve this role in the future.

The DoD desired system outcomes, which we propose in Chapter 3 and present again here as follows, shape the competencies required for primary participants to produce the desired on-the-job results:

1. Service members having a similar condition and similar office, grade, rank, or rating receive similar fitness decisions within the military department.
2. Service members found unfit receive similar disability ratings for similar conditions across and within the military departments.
3. Service members freely and appropriately exercise their rights to administrative due process.
4. Service members return to duty, separate for disability, or retire for disability in a timely manner.

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[8]*Job analysis,* also known as *job-task analysis,* is the examination of the parts of a job. In this case, it is an analysis of the parts of the jobs of the primary participant populations: physicians who write narrative summaries; PEBLOs and disability evaluation counselors; patient administrators; Medical Evaluation Board members and approving authorities; PEB administrative action officers, members, and approving authorities; appellate review board members beyond the PEB; and unit commanders (regarding interaction with the DES). Job analysis entails understanding the desired job results, the sequence of the parts of the job, the frequency of performance of the parts, their criticality to successful performance, and accompanying bodies of knowledge.

5. Primary participants perform their duties as efficiently as possible so that, collectively, they return service members to duty, or separate or retire service members for disability in a fair, consistent, and timely manner.[9]

Given the existing job designs for primary participant populations, we translated these statements of desired system outcomes into the following statements that describe the major activities that the primary participant populations must be able to perform to achieve the desired system outcomes:

Members of Medical Evaluation Boards

- Apply disciplined medical retention standards uniformly such that members having a similar condition and similar office, grade, rank, or rating receive similar medical retention decisions
- Apply the correct rules in a disciplined manner and document the substantial evidence that supports the decision to refer the service member to a PEB.

Members of Physical Evaluation Boards and Appellate Review Boards

- Uniformly apply fitness standards such that members having a similar condition and a similar office, grade, rank, or rating receive similar fitness decisions within the military department
- Uniformly rate service members found unfit, such that members having a similar condition and a similar office, grade, rank, or rating, receive similar disability ratings across and within the military departments
- Apply the correct rules in a disciplined manner and document the substantial evidence that supports all decisions (fitness, rating, and disposition).

PEBLOs and attorneys

- Provide complete and accurate information so that service members have sufficient understanding of the process and their rights so that they may exercise their rights to due process under the law.

All primary participants

- Perform their duties as effectively as possible so that, collectively, they return service members to duty, separate service members for disability, or retire them for disability in a timely manner.

These statements shaped the formulation of the following competencies for ten of the primary participant populations. The following suggested competencies, in turn, help to better focus the training intervention recommendations:

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[9]The fifth proposed desired outcome is so pervasive that it does not link *directly* to individual primary participant population competencies or to specific training content; nonetheless, as an intended result of operating the system to achieve its stated purpose, it influences training needs assessment and design. In this particular case, the *collective* training recommendations contribute to achieving this desired system outcome.

Physicians who write narrative summaries

- Able to determine the appropriate diagnosis
- Able to determine if service member's condition calls into question his or her ability to meet medical retention standards
- Able to synthesize a service member's medical evidence from all appropriate consultations into a single narrative summary that contains sufficient information in the appropriate format for a PEB to adjudicate the case.

PEBLOs and Disability Evaluation Counselors

- Able to accurately advise service members on the process and of their rights, benefits and entitlements, and what to expect as the service member's medical board progresses through the DES
- Able to gather and process patient information to assemble medical boards (case files) that contain sufficient information in the appropriate format for a PEB to adjudicate the case.

Patient Administrators

- Able to assist Medical Evaluation Boards and PEBLOs in gathering and processing patient information to assemble medical boards that contain sufficient information in the appropriate format for a PEB to adjudicate the case.

Medical Evaluation Board Members

- Able to determine whether the medical board includes appropriate specialty consultations with sufficient information
- Able to determine the duty limitations associated with the diagnosis
- Able to determine whether the service member meets the military department's medical retention standards for continued military duty.

Medical Evaluation Board Approving Authorities

- Able to identify complete and accurate medical boards

PEB Administrative Action Officers

- Able to ensure contents of medical boards received by the PEB are complete and accurate for adjudication
- Able to obtain missing information, monitor, and move medical boards through the system, and exchange information with PEBLOs.

Physical Evaluation Board Members

- Able to apply disciplined military department fitness standards in a uniform manner

- Able to apply other rules uniformly such that members having a similar condition and a similar office, grade, rank, or rating receive similar disability ratings across and within the military departments
- Able to document the substantial evidence that supports all PEB decisions.

Physical Evaluation Board Approving Authorities

- Able to identify correct and consistent application of military department fitness standards such that members having a similar condition and a similar office, grade, rank, or rating, receive similar fitness decisions within the military department
- Able to identify correct and consistent application of other rules such that members having a similar condition receive similar disability ratings across and within the military departments
- Able to identify sufficient documentation of the substantial evidence that supports all PEB decisions.

Post-PEB Appellate Review Board Members

- Able to apply disciplined military department fitness standards in a uniform manner
- Able to apply other rules uniformly such that members having a similar condition receive similar disability ratings across and within the military departments
- Able to document the substantial evidence that supports all decisions.

Unit Commanders

- Able to provide written evidence with sufficient detail for PEB consideration that documents his or her judgment of how a service member's medical condition impacts the member's ability to perform the duties of the member's office, grade, rank, or rating including his or her ability to deploy, and pending adverse actions.

We consider attorneys who advise and represent service members and unit commanders (both active and Reserve component) who interact with the DES as populations external to the system. Primary participants raised no issues regarding Reserve component commanders or due process; therefore, we did not focus on articulating competencies for Reserve commanders and attorneys. Nevertheless, primary participants across the military departments identified active component unit commanders as a major source of delay in processing cases; therefore, we formulated a unit commander competency.

Establishing common competencies for primary participant populations across military departments is a critical factor in developing a DoD-wide training intervention that leads to more-consistent application of DoD disability policy; as stated earlier in this chapter, job analysis is the preferred technique. These suggested competencies point to a training emphasis on DES topics.

Training Content: DES Topics

The DoD desired system outcomes not only shape the performance competencies for individuals assigned to the DES but also point to a DoD emphasis on DES topics and skills in applying knowledge of those topics, across the military departments. Nearly all of the DES topics suggested in this report emanate directly from the governing statutes and OSD policy documents. In the few instances in which they do not, they flow directly from other management interventions recommended in this report—interventions that logically precede implementation of the recommended training interventions.

This OSD-sponsored study focuses on recommending changes to training in order to ensure more consistent application of disability policy. The OSD focus on consistent policy application suggests that DES topics and the associated skills required to apply knowledge of those topics are the most relevant aspects of a DoD training intervention.

As a result, we compiled a comprehensive list, which appears in Appendix G, of DES topics from policy documents and current military department disability-training syllabi. We associated each suggested topic with the primary participant populations who require knowledge of that topic to produce the desired on-the-job results, recognizing that different populations may apply the same knowledge differently in their respective jobs. The list in Appendix G highlights the scope of suggested DES subjects required by each primary participant population. Figure 5.2 shows the percentage of DES topics in which each primary participant population must possess some expertise. Although the figure depicts the quantity of DES topics, it does not provide an indication of the complexity of those particular topics or how deeply the participant population needs to know any given topic within its associated body of knowledge.

The proposed competencies introduced earlier in this chapter, together with an analysis of DES topics, indicates that the primary participant populations listed within the five clusters shown in Table 5.2 require different levels of knowledge of essentially the same DES topics. This analysis suggests designing the training content—that is, the DES topics—in five distinct training packages, one per population cluster, as described later in this chapter.

It is important to restate that different primary participants apply the same knowledge in different ways to produce the desired results in their respective jobs. In other words, different primary participant populations require different *skills* to apply different levels of knowledge of DES topics to their respective jobs. For example,

- Physicians who write narrative summaries apply their knowledge of "sufficient narrative summaries" to dictating the kind of detailed information and formatting needed by the PEB to adjudicate a case.
- Patient administrators apply their knowledge of "sufficient narrative summaries" to formatting the data dictated by the physician.

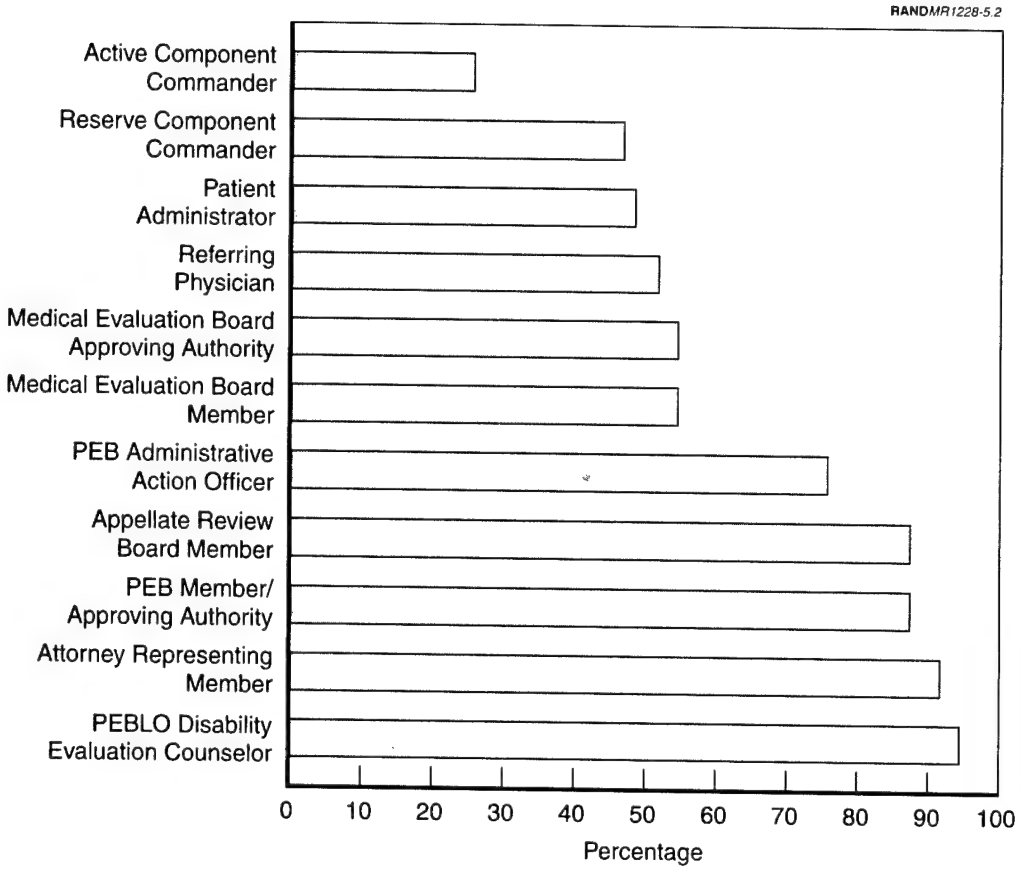

Figure 5.2—Percentage of Disability Evaluation System–Specific Topics in Which Primary Participants Must Exhibit Expertise

Table 5.2

Primary Participant Population Clusters

Population Cluster 1	PEBLOs and disability evaluation counselors Patient administrators PEB administrative action officers
Population Cluster 2	Physicians who write narrative summaries Medical Evaluation Board members Medical Evaluation Board approving authorities
Population Cluster 3	PEB members PEB approving authorities[a] Post-PEB Appellate Review Board members Attorneys who represent service members
Population Cluster 4	Active component unit commanders
Population Cluster 5	Reserve component commanders

[a] These authorities are the Deputy Commander, Army Physical Disability Agency; President, Physical Evaluation Board (Department of the Navy); and Chief, Air Force Physical Disability Division.

- PEBLOs and disability evaluation counselors, patient administrators, and PEB administrative action officers apply their knowledge of "sufficient narrative summaries" to perform a quality check on the medical board. They compare the physician's narrative description to the individual specialty consultations and specialty measurements required for the PEB to adjudicate the case; they ensure the referring physician's specialty matches the type of diagnosis; and they monitor the date signed.
- The PEB administrative action officers apply their knowledge of "sufficient narrative summaries" to turn back insufficient medical boards for correction and forward sufficient medical boards to the PEB for adjudication.
- PEB members apply their knowledge of "sufficient narrative summaries" to turn back insufficient medical boards and adjudicate sufficient ones.

In summary, the suggested purpose statement for DES and the desired system outcomes presented in this report, and the issues highlighted by the primary participants, shaped the suggested competencies for the primary participant populations. The proposed purpose, desired outcomes, participant issues, and proposed competencies, in turn, shaped the training content—the extensive list of suggested DES topics in which primary participants require knowledge and expertise to produce desired on-the-job results. The next section considers various aspects of training design that impact training delivery methods.

TRAINING DESIGN

Other considerations, in addition to the system's stated purpose, desired outcomes, competencies, and content, affect training design. For example, newly assigned individuals *need* a certain amount of DES-specific knowledge *immediately* to perform their jobs effectively. But do all primary participant populations need to know *all* of the topics within the body of knowledge suggested for that population, or just a subset of them, to produce desired results immediately?

In addition, the frequency of use of DES-specific knowledge, assignment practices that result in high turnover rates among some primary participant populations, widely dispersed primary participant populations, and the availability of information currently on the World Wide Web—all related to the characteristics of the target training population—impact the choice of training delivery method. Likewise, learning effectiveness associated with different delivery methods may vary (in particular, the effectiveness of self-directed computer-based distance training versus the effectiveness of traditional classroom training). These considerations are addressed in the following sections. Cost, another important consideration, is addressed in Chapter 7.

DES-Specific Knowledge Needed Immediately Upon Assignment

Every disability case is unique. Every disability case that a primary participant handles, including the first one, potentially requires the PEBLO, the physician, the PEB

member, and any other primary participant to bring to bear any aspect of the specific body of knowledge and skills required for that primary participant to produce the desired on-the-job results. A primary participant who (1) does not know or apply a single relevant policy application standard or rule; (2) does not follow a prescribed, disciplined procedure; (3) does not document the rationale that underlies the decisions; or (4) does not focus on desired system outcomes, invites the risk of inconsistent application of disability policy.

From a performance perspective, every primary participant requires knowledge in every DES topic that constitutes the body of knowledge for that particular primary participant population *before* handling a disability case. Every case handled may require knowledge of any combination of topics within the particular body of knowledge. However, as discussed next, not every primary participant requires training immediately upon assignment.

Frequency with Which Primary Participants Apply DES-Specific Bodies of Knowledge

PEBLOs, PEB members and approving authorities, and PEB administrative action officers generally work full time in the DES; therefore, they apply their specific body of knowledge daily. Attorneys collocated with Formal PEBs,[10] who represent service members, also generally apply their specific body of knowledge on a daily basis. Others, especially PEBLOs and disability evaluation counselors, patient administrators, Medical Evaluation Board members and approving authorities, who perform disability related tasks as a collateral duty may apply aspects of their specific body of knowledge only a few times per month. At the other end of the spectrum, physicians who write narrative summaries and unit commanders generally interact sporadically with the system and, therefore, apply DES-specific knowledge only sporadically and infrequently. For example, many Army unit commanders typically write no more than two nonmedical assessment letters during their 12- to 18-month command.

The frequency with which different primary participant populations apply their DES-specific bodies of knowledge influences the choice of training delivery method. Those primary participants who apply DES-specific knowledge frequently as a major part of their job stand to benefit from training at the beginning of their assignment to a position in the DES. Likewise, primary participants who use this knowledge infrequently stand to benefit from "just-in-time" training. In both cases, training made available on an as-needed basis is an important consideration in choosing a delivery method.

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[10]Attorneys collocated with Formal PEBs do not work for the PEB.

Assignment Practices Causing High Turnover Rates Among Some Primary Participants

Combined with the frequency of use of specific bodies of DES knowledge, certain assignment practices—such as selecting individuals with no DES knowledge and skills for primary participant positions and relatively frequent rotations of military personnel—exacerbate the risk of inconsistent disability policy application. The assignments of some primary participants are more stable than others. For example, military department civilian employees assigned as PEBLOs and civilian physicians who write narrative summaries and serve as PEB members remain in their positions for longer periods than their military counterparts.

From a training perspective, these personnel management policies create a need for more-frequent training delivery. As noted in the previous section, training availability on an as-needed basis is an important consideration in choosing a delivery method to mitigate the effects of frequent turnover.

Widely Dispersed Primary Participant Populations

As noted earlier in this chapter, physicians are the most widely dispersed population because virtually any physician in an MTF may write a narrative summary. PEBLOs, disability evaluation counselors, patient administrators, and physicians located wherever MTFs exist and who serve on Medical Evaluation Boards are also widely dispersed.

PEB members, approving authorities, and administrative action officers in the three military departments are assigned to eight separate locations. Attorneys who represent service members are currently dispersed over the same six locations as the Formal PEBs. Conducting Formal PEBs via teleconferencing, which the Army is exploring, increases the dispersion of attorneys who interact with the DES because the technology allows them to do their job from virtually any military installation. Active and Reserve component unit commanders who interact with the DES from potentially any military installation and deployment are the most-dispersed populations.

Although organized into five training population clusters, the dispersion of the 12 primary participant populations presents yet another consideration in choosing a training delivery method. Widely dispersed target training populations stand to benefit from "transportable" training packages that are easily accessible regardless of the dispersion pattern.

Military Department DES Web Sites

Each of the military departments' Disability Evaluation Systems faces the challenges associated with widely dispersed primary participants on a daily basis. As a result, they have established or are in the process of establishing a presence on the World Wide Web as a valuable resource for sharing information. Web sites in various stages of development exist today. The Army has two DES Web sites: the U.S. Army Medical

Command site at www.armymedicine.army.mil/pad and the U.S. Army Personnel Command site at www.perscom.army.mil/tagd/pdapage.htm.

The Web site for the Air Force Physical Disability Division can be found at www.afpc.randolph.af.mil/disability and the Department of the Navy PEB Web site is at www.hq.navy.mil/ncpb as of this writing. Other Web sites developed by individual PEBLOs also exist.

Many primary participants who are continuously exploring new tools with which to improve the performance of their DES have identified the Web as an information source that meets many of their needs. Acceptance of and comfort with ad hoc computer-based training points to self-directed computer-based distance training as a viable training delivery method.

Advantages and Disadvantages of Self-Directed Computer-Based Distance Training and Classroom Training

A common cultural trait across all military departments is the high commitment to excellence in training, regardless of the training method. Numerous studies in the training literature report "no significant difference" between self-directed computer-based distance learning and traditional classroom learning. *The ASTD Training and Development Handbook* (Craig, 1996) reports, "Eighty-five percent mastery on a good SDL (self-directed learning) package is common, and 95 percent is not unusual." And, other studies report superior results from one method over the other.

As the debate on effectiveness of distance learning continues, Public Law 105-261, enacted on October 17, 1998, required the Secretary of Defense to develop and submit to Congress by March 1, 1999, a strategic plan for guiding and expanding distance-learning initiatives within the DoD, focusing on the goals and objectives of DoD training and education. The plan also provides for expansion of distance-training initiatives over five consecutive years beginning with fiscal year 2000.

Based on the preceding design considerations, we identified the following advantages and disadvantages of self-directed computer-based distance training and classroom training for primary participants, military departments, and the OSD. This analysis includes comparisons of current military department training practices and proposed training packages developed and monitored by the OSD.

Primary Participants: Advantages of Self-Directed Computer-Based Distance Training

- Available when primary participant needs training, upon assignment
- Tailored to specific training needs of each training population
- Provides up-to-date review and reference source
- Primary participant learns at own pace
- Immediate feedback
- No surprise questions or pop tests

- Individual chooses order of material
- Promotes computer literacy

Primary Participants: Disadvantages of Computer-Based Distance Training

- Some not used to being self-directed learners
- Some not comfortable relying on training objectives instead of faculty
- Lack of faculty presence
- Lack of group synergy

Primary Participants: Advantages of Classroom Training

- Practice applying specific body of knowledge develops skills to produce consistent determinations
- Peer networking across military departments builds collaborative relationships
- Synergy of group
- Reassurance from adjunct faculty
- Immediate answers to questions
- Immediate feedback
- Discover others have same problems
- Case studies provide review and reference source

Primary Participants: Disadvantages of Classroom Training

- Infrequent training schedule; training not always available when primary participants need it
- Rigid learning schedule
- Time away from job

Military Departments: Advantages of Self-Directed Computer-Based Distance Training

- Requires fewer trainers/faculty
- Less time on the road for PEB members, approving authorities, and administrative action officers
- Reduces trainer/faculty travel and lodging expenses
- Consistent with high-tech military of the future
- Just-in-time training
- Up-to-date reference for on-the-job training
- Standardized bodies of DES-specific knowledge for each primary participant population cluster

- Multiple-site training
- No primary participant travel and lodging costs

Military Departments: Disadvantages of Self-Directed Computer-Based Distance Training

- Reduces OSD policy interpretation flexibility
- Requires designated training facilitators to be accessible to all primary participants
- Requires all primary participants have computer access to Web site

Military Departments: Advantages of Classroom Training

- Requires less operational downtime for PEB members, approving authorities, and administrative action officers to prepare and deliver military department classroom training
- Requires fewer military department trainers/faculty
- Reduced training costs
- Standardized bodies of DES-specific knowledge
- References for on-the-job training

Military Departments: Disadvantages of Classroom Training

- Reduces OSD policy interpretation flexibility
- Primary participants' travel and lodging costs

Office of the Secretary of Defense: Advantages of Self-Directed Computer-Based Distance Training

- Reduces likelihood of misinterpreted OSD policy
- Multiple-site training across military departments
- Training consistency and quality
- Standardized DES-specific bodies of knowledge
- Direct link between OSD policy and training
- Just-in-time training
- Consistent with high-tech military of the future
- Changes posted immediately to all primary participants
- No primary participant travel and lodging costs
- No faculty travel and lodging expenses
- No meeting-room and materials costs

Office of the Secretary of Defense: Disadvantages of Self-Directed Computer-Based Distance Training

- Difficult to develop properly
- Design and development costs
- Development time
- Requires a Webmaster
- Possible logistics problems with different computer systems

Office of the Secretary of Defense: Advantages of Classroom Training

- Reduces likelihood of misinterpreted OSD policy
- Direct link between OSD policy and training
- Standardized bodies of DES-specific knowledge
- Develop a more "Joint" DES culture
- Networking among primary participants from all military departments leads to more-consistent application of DES-specific knowledge and skills

Office of the Secretary of Defense: Disadvantages of Classroom Training

- Training consistency and quality may vary by adjunct faculty
- Requires adjunct faculty
- Adjunct faculty travel and lodging costs
- Meeting-room and materials costs
- Design and development costs
- Development time

DEPARTMENT OF DEFENSE TRAINING RECOMMENDATIONS

Based on our assessment of training needs and the design considerations, this section describes our recommendations for DoD disability evaluation training.

Achieving the outcomes suggested in Chapter 3, and meeting the goal of consistent application of disability policy across and within military departments, requires primary participant populations across the military departments to possess common performance competencies including specific bodies of DES knowledge and the necessary skills to produce the desired on-the-job results. We recommend that the Office of the ASD/FMP develop and monitor knowledge-based training in which the content focuses on the suggested list of DES topics that collectively constitute a specific body of knowledge for each primary participant population cluster. We further recommend delivering this knowledge-based training through a Web site devoted to disability evaluation training and made accessible to all primary participants.

This self-directed computer-based distance training is a basic course in disability evaluation. It is supplemented with classroom training that focuses on applying a particular set of the DES topics within two of the primary participant population clusters' bodies of knowledge in order to develop the skills necessary to evaluate and adjudicate cases consistently across and within the military departments, a primary determinant of consistent application of disability policy.

Recommendations for Self-Directed Computer-Based Distance Training

In order to deliver standardized training when it is needed—so-called just-in-time training—to every primary participant of the DES, we recommend that the OSD establish, monitor, and maintain a Web site devoted to disability evaluation training. A great strength of this training delivery method is that it allows training designers to tailor content to specific targeted training populations. In this case, the DES topics that constitute the body of knowledge suggested for each primary participant population cluster across the military departments serves as the basis for developing content.

Table 5.3 organizes the comprehensive list of DES topics into five distance-training packages, each designed to meet the training needs of a particular primary participant population cluster. It further organizes the topics roughly in descending order of common training needs across population clusters, starting with those topics required by all population clusters, and ending with those topics required by only one cluster.

Clearly, all five population clusters need knowledge of many of the same DES topics, although different population clusters need to know how to apply some topics in different ways to achieve their specific desired on-the-job results. Although the different training packages contain many of the same DES topics, the learning objectives, content presentation, and criterion referencing,[11] addressed later in this chapter, should match the specific job application needs of each target population cluster (and some will be the same).

The full range of information included in some DES topics appears in italics under each shaded area in Table 5.3. Note, in particular, that not all primary participant populations require knowledge of all the DES topics.

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[11] *Criterion referencing* refers to the method of testing that is most often used in self-directed computer-based distance training. The test questions are written directly from the stated learning objectives and can be answered directly from the material presented. In other words, criterion-referenced tests contain no hidden meanings or trick questions.

Table 5.3

Disability Evaluation System Topics Sorted According to Population-Cluster Training Packages

DES Training Content	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Statutory basis of the DES	1	1	1	2	2	2	3	3	3	4	5
References (statutes, directives, instructions)	1	1	1	2	2	2	3	3	3	4	5
DoD DES Purpose	1	1	1	2	2	2	3	3	3	4	5
DoD DES Desired Outcomes	1	1	1	2	2	2	3	3	3	4	5
Role of primary participants in the DES	1	1	1	2	2	2	3	3	3	4	5
DES (process and steps)	1	1	1	2	2	2	3	3	3	4	5
Ready Reserves	1	1	1	2	2	2	3	3	3	4	5
Acronyms	1	1	1	2	2	2	3	3	3	4	5
Assignment limitation codes/physical profiles	1	1	1	2	2	2	3	3	3	4	5
Purpose of Medical Evaluation Board	1	1	1	2	2	2	3	3	3	4	5
How a service member gets referred to a Medical Evaluation Board	1	1	1	2	2	2	3	3	3	4	5
Medical Evaluation Board range of dispositions	1	1	1	2	2	2	3	3	3	4	5
Imminent death procedures	1	1	1	2	2	2	3	3	3	4	5
Impairment versus disability	1	1	1	2	2	2	3	3	3	4	5
Non-duty-related impairment (Reserve component)	1	1	1	2	2	2	3	3	3	4	5

Table 5.3—Continued

DES Training Content	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Range of Disability Dispositions											
Fit, return to duty	1	1	1	2	2	2	3	3	3	4	5
Unfit, separate with severance pay	1	1	1	2	2	2	3	3	3	4	5
Unfit, separate without disability benefits	1	1	1	2	2	2	3	3	3	4	5
Unfit, permanent disability retirement	1	1	1	2	2	2	3	3	3	4	5
Unfit, temporary disability retirement list (TDRL)	1	1	1	2	2	2	3	3	3	4	5
Fact versus opinion	1	1	1	2	2	2	3	3	3	4	5
Unfit versus unsuitable (conditions that do not constitute a physical disability)	1	1	1	2	2	2	3	3	3	4	5
Medical evidence in case adjudication	1	1	1	2	2	2	3	3	3		
Optimum medical treatment benefits	1	1	1	2	2	2	3	3	3		
Narrative summary template (contents and format)	1	1	1	2	2	2	3	3	3		

Table 5.3—Continued

DES Training Content	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Medical Board Contents	1	1	1	2	2	2	3	3	3		
Sufficient narrative summaries	1	1	1	2	2	2	3	3	3		
Appropriate specialty consults	1	1	1	2	2	2	3	3	3		
LOD determinations (Notice of Eligibility for Navy Reserves)	1	1	1				3	3	3	4	5
Complete physical examination (SF 88/93)	1	1	1	2	2	2	3	3	3		
CCEP Data	1	1	1	2	2	2	3	3	3		
Documents dated within last 90 days	1	1	1	2	2	2	3	3	3		
Appropriate signatures	1	1	1		2	2	3	3	3		
Necessary Medical Data in Sufficient Detail to Enable PEBs to Adjudicate Cases	1	1	1	2	2	2	3	3	3		
Orthopedic cases (in particular, backs)	1	1	1	2	2	2	3	3	3		
Neurological/neurosurgical cases (in particular, backs)	1	1	1	2	2	2	3	3	3		
Ophthalmologic cases	1	1	1	2	2	2	3	3	3		
Pulmonary cases	1	1	1	2	2	2	3	3	3		
Cardiological cases	1	1	1	2	2	2	3	3	3		
Psychiatric cases (in particular, epilepsy and narcolepsy)	1	1	1	2	2	2	3	3	3		
Migraine headache–related cases	1	1	1	2	2	2	3	3	3		

Table 5.3—Continued

DES Training Content	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
When Specialty Consults Are Required for the Following Conditions and the Diagnostic Details That Are Required	1	1	1	2	2	2	3	3	3		
Fibromyalgia	1	1	1	2	2	2	3	3	3		
Chronic fatigue syndrome	1	1	1	2	2	2	3	3	3		
Gulf War Syndrome/ Southwest Asia theater of operations–related CCEP	1	1	1	2	2	2	3	3	3		
Psychiatric diagnoses/neuropsychological testing for head injury patients	1	1	1	2	2	2	3	3	3		
HIV	1	1	1	2	2	2	3	3	3		
Composition (members) of a Medical Evaluation Board	1	1	1	2	2	2	3	3	3		
Incompetency cases	1	1	1	2	2	2	3	3	3		5
TDRL Statutory Requirements											
TDRL reevaluations	1	1	1	2	2	2	3	3	3		
Retention standards considered by Medical Evaluation Board	1	1	1	2	2	2	3	3	3		
Preponderance of evidence	1		1	2	2	2	3	3	3		

Table 5.3—Continued

DES Training Content	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Compensability Criteria											
Proximate result	1		1	2	2	2	3	3	3		
Presumptions of service incurred/aggravated and overcoming presumptions	1		1	2	2	2	3	3	3		
Conditions presumed to be preexisting	1		1	2	2	2	3	3	3		
Noncompliance (refusal of treatment)	1		1	2	2	2	3	3	3		
Accepted medical principals	1		1	2	2	2	3	3	3		
Natural progression	1		1	2	2	2	3	3	3		
Organization of the VASRD plus supplements (currently 26) and updates	1		1	2	2	2	3	3	3		
Analogous codes (in DoD Instruction 1332.39 and updates) that supplement the VASRD	1		1	2	2	2	3	3	3		
Military department analogous codes that supplement the VASRD and DoD Instruction	1		1	2	2	2	3	3	3		
Documentation of rationale supporting Medical Evaluation Board decision	1		1		2	2	3	3	3		

Table 5.3—Continued

DES Training Content	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Appealing Medical Evaluation Board decisions	1	1		2	2	2			3		
Difference between VA and DoD Disability Evaluation Systems	1			2			3	3	3	4	5
Commander's Letter or Nonmedical Assessment	1	1	1				3	3	3	4	5
Timely response	1	1	1				3	3	3	4	5
Judgment regarding how condition impacts service member's ability to perform duty	1	1	1				3	3	3	4	5
Judgment regarding service member's ability to deploy	1	1	1				3	3	3	4	5
Adverse actions pending	1	1	1				3	3	3	4	5
Permanent limited duty (continuation on active duty or active Reserve status)	1		1				3	3	3	4	5
Eligibility for referral for full disability adjudication including checklist to determine eligibility	1		1				3	3	3		
Presumption of fitness rule and overcoming presumptions	1		1				3	3	3		5

Table 5.3—Continued

DES Training Content	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Effect of PEB findings and decision	1		1				3	3	3		5
Temporary early retirement authority	1		1				3	3	3		5
Waiver of disability retirement pay for Reserve retirement	1		1				3	3	3		5
Service member election of options	1		1				3	3	3		5
Standards for determination of fitness	1		1				3	3	3		5
Compensability Criteria											
15-year rule for early qualification for retired pay for members of the selected Reserve	1		1				3	3	3		5
Adjudication of TDRL reevaluations	1		1				3	3	3		5
Processing Reserve component non-duty-related cases	1		1				3	3	3		5
Formal PEB presentation	1		1				3	3	3		5
Appeal opportunities	1		1				3	3	3		5

Table 5.3—Continued

DES Training Content	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Compensability Standards											
Prior service impairments	1						3	3	3		5
Reserve component performing duty of 30 days or less	1						3	3	3		5
Service member rights, benefits, and entitlements	1						3	3	3		5
Service member restrictions imposed by the DES	1						3	3	3		5
Disability (separation and retirement) compensation computation	1						3	3	3		5
Procedure for rating by analogy; use of hyphenated codes in disability adjudication	1						3	3	3		5
What is required to increase percentage of disability determined by the PEB	1						3	3	3		5
TDRL Statutory Requirements											
Retired pay while on TDRL remains constant at 50% to 75% of base pay, although rating may be less	1						3	3	3		

Table 5.3—Continued

DES Training Content	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Combined ratings/overall effects	1						3	3	3		
Bilateral factor	1						3	3	3		
Pyramiding	1						3	3	3		
Dual processing cases	1		1				3	3	3		
Adjudication of cases involving mental disorders	1		1				3	3	3		
Documentation of rationale supporting PEB decision	1		1				3	3	3		
Processing physicians and general officers	1		1				3	3	3		
Administrative determinations for purposes of employment under federal civil service	1						3	3	3		
Administrative determinations for federal tax benefits	1						3	3	3		
Zero-percent ratings	1						3	3	3		
Severance pay tax refund	1						3	3	3		
Administrative finality	1						3	3	3		
Abuse of discretion	1						3	3	3		
Waiver of DES processing	1		1						3		5
Calculation of effective date of separation or retirement	1		1						3		5

Table 5.3—Continued

DES Training Content	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Potential benefits from the VA	1								3		5
Medical board coordination among service member, MTF, PEB, and military department personnel organizations	1		1								5
Final administrative disposition of disability separations and retirements	1		1								
Survivor benefit plan	1										
Template for managing disability case appeal[a]									X		

[a]The DES topic "Template for managing disability case appeal" applies only to attorneys and, therefore, is not included in Training Package 3 because this training package is not designed specifically for attorneys. The DES topics contained in the training package seem to match attorneys' needs, so we included attorneys in that training population cluster. We retained this particular topic here, however, because it is an important case management tool for attorneys.

The DES topics in each of the proposed training packages target a particular primary participant population cluster to enable the primary participants within the cluster to produce the desired on-the-job results. A description of each proposed training package follows:

Training Package 1 is designed for Population Cluster 1, which is composed of PEBLOs and disability evaluation counselors, patient administrators who support PEBLOs, and PEB administrative action officers who quality-check and move medical boards to the appropriate recipients (to physicians for more information or an appropriate signature or to the PEB). PEBLOs require expertise in the greatest number of DES topics to produce desired results, and although patient administrators and PEB administrative action officers require expertise in fewer DES topics, their needs are similar enough to PEBLOs to merit a common distance-training package. PEBLOs and disability evaluation counselors will simply complete all modules, whereas patient administrators and PEB administrative action officers will complete only those modules relevant to producing their desired on-the-job results.

Training Package 2 is designed for Population Cluster 2, composed of referring physicians—those who write narrative summaries, Medical Evaluation Board members, and Medical Evaluation Board approving authorities. All three populations within this cluster require expertise in the same set of DES topics, except for two. Only the physician who interacts with the service member needs to know the differences between DoD and VA disability systems so that he or she does not verbally misrepresent any differences to the service member and, therefore, create unrealistic expectations on the part of the member.[12] Likewise, the referring physician does not need to know how to write documentation to support the Medical Evaluation Board decision.

Training Package 3 is designed for Population Cluster 3, composed of PEB members and approving authorities and post-PEB level appellate review authorities. PEB members emphasized the need for appellate review board members who are beyond the Formal PEB to know all of the standards, rules, and other considerations, and the prescribed, disciplined procedures that are applied throughout case adjudication. Otherwise, it is difficult for the appellate review board members to make seasoned judgments. Our analysis indicated that attorneys who advise and represent service members during an appeal to the Formal PEB require knowledge of the same set of DES topics, as the details pertain to an individual case. Although this training package is not designed explicitly for attorneys, it closely matches their needs; therefore, they are included in this population cluster.

Training Package 4, the smallest of the five packages, is designed for Population Cluster 4, composed solely of active component unit commanders. It contains DES topics of which active component unit commanders require knowledge to produce desired results when they interact with the DES. These topics include how to prepare

[12]Although it is not the physician's role to counsel the service member on either the DoD or VA system, several primary participants reported that physicians often say things to service members that create unrealistic expectations.

and submit a nonmedical assessment (commander's letter) and an LOD determination on a service member. It also includes topics related to the differences between the DoD and VA disability systems so that the unit commander can avoid verbally misrepresenting any differences to the service member and, therefore, create unrealistic expectations.

Training Package 5 is designed for Population Cluster 5, composed solely of Reserve component commanders. It contains a blend of DES topics of which PEBLOs and active component unit commanders must possess knowledge to accomplish their desired results. It includes many DES topics otherwise associated with PEBLO population, in particular, topics that are intended to enable the Reserve component commander to provide accurate information to the reservist who has limited access to a PEBLO.

We identified no need for DoD disability evaluation training for the larger personnel community that administratively returns the service member to duty or out-processes and issues orders for those separated or retired for disability.

If a later assessment of training effectiveness demonstrates that these training packages do not enable the primary participant populations to produce the desired on-the-job results, the OSD should modify the training packages so that they perform as intended.

Development of the actual self-directed computer-based distance-training curriculum is beyond the scope of this study. Nevertheless, we outline a developmental approach in the context of our other recommendations later in this chapter. Development of computer-based distance-training curriculum entails four critical factors: job analysis, learning objectives, training content, and criterion referencing (Craig, 1996).

Job analysis is critical to identifying all of the required tasks (including the knowledge required to accomplish those tasks) for each primary participant population to produce the desired on-the-job results. Thorough job analysis of each primary participant population is the critical first step to developing a self-directed computer-based distance-training package. The product of job analyses forms the basis for writing learning objectives for each training population cluster.

Writing learner-centered objectives, each directly related to the required body of knowledge and skills identified in the primary participant population job analysis, is the second critical step in developing a self-directed computer-based distance-training package. Learning objectives take the place of faculty in the classroom; they guide learners through the training package by communicating what is most important and what the learner must master. Developing content that relates directly to the learning objectives and that presents information in sufficient detail for the learner to master the objectives is the third critical step. Content, written as concisely as possible, includes sufficient detailed information for the learner to master the knowledge and skills required to achieve the learning objectives.

In many instances, the five training packages contain the same learning objectives and content. In other cases, different population clusters require different learning objectives pertaining to the same DES topics as they relate to jobs within specific primary participant population clusters. For example, the physicians' training package (Package 2) content includes information in sufficient detail by specialty—in particular, the five specialties that represent the majority of consults—to enable physicians to write sufficiently detailed and complete narrative summaries and specialty consults. The physicians' training package also specifies the special tests and measurements that they must include for the PEB to determine a VASRD rating. Similarly, the unit commanders' training package (Package 4) includes enough detailed information for commanders to write sufficiently detailed and complete nonmedical assessment letters and prepare sufficiently detailed and complete LOD determinations.

The various training packages' content may also include sample documents required to process cases through the DES, such as well-written and sufficiently detailed and complete narrative summaries, specialty consults, and nonmedical assessments.

Last, writing test questions directly from the learning objectives that learners can answer directly from the content presented—that is, criterion referencing—is the fourth critical step in developing self-directed computer-based distance learning. Self-directed learning is often considered a mastery process because, when executed properly, learners know what is expected of them, find what is required in an efficient manner, and answer test questions and demonstrate mastery based on the content presented in the training package.

The design parameters of these five just-in-time training packages extend their utility beyond pure training materials to serving as an up-to-date and comprehensive desktop reference tailored to the needs of each population cluster. For example, both the physicians' and unit commanders' training packages (Packages 2 and 4) ideally include embedded links to electronic-based templates that enable them to write and electronically submit narrative summaries and specialty consults, or nonmedical assessments (commanders' letters). Links to a set of frequently asked questions of potential interest to all primary participants, cohorts, and centrally located experts, and links to all of the DES references including relevant statutes and OSD and military department policy documents extend the value of the training packages.

This self-directed computer-based distance-training method benefits from on-site facilitators to guide learners through the distance-learning process. Very experienced peers or supervisors may serve as facilitators, and facilitators may certify satisfactory completion of individual training goals and objectives.

Section 4.4.5 of DoD Directive 1332.18 assigns responsibility to the Secretaries of the military departments to ensure that PEB members and applicable review authorities are trained and certified in physical disability evaluation. Well-designed self-directed computer-based training is a natural for use as a certification tool, particularly self-certification. This approach to certification is a matter of (1) constructing learning objectives, content, and test questions that meet desired certification standards for the target population, (2) building in an honor system, and (3) designing the training

package for each target population cluster such that primary participants in that population cluster can self-certify their mastery of required knowledge and skills. Supervisors may also choose to certify a primary participant's competence by combining the self-certification test results with observed job performance.

One final point on self-directed computer-based distance training: Selecting experienced and credible subject-matter experts and technical designers who are able to develop high-quality training that produces the desired on-the-job results from the populations trained is also critically important. The subject-matter experts actually serve as adjunct faculty who are delegated authority by the OSD to develop the DoD disability evaluation training.

Recommendations for Classroom Training

At this point, we assume that the OSD has developed a Web site devoted to disability evaluation training and has established the recommended self-directed, computer-based distance-training packages. We further assume the training packages "teach" the DES topics to the degree intended. Now, the question is, do primary participants require additional training to apply policy consistently across and within military departments to produce the desired on-the-job results?

To answer this question, we reexamined the proposed primary participant competencies presented earlier in this chapter. The competency statements suggest that PEB members, PEB approving authorities, and post-PEB appellate review board members across military departments, in particular, stand to benefit from collaboration with peers on how to uniformly apply the rules, procedures, and other considerations in determining fitness, assigning the VASRD or analogous codes, and determining disability ratings.

Likewise, Medical Evaluation Board members and approving authorities across military departments stand to benefit from collaboration with peers regarding how to apply disciplined medical retention standards uniformly such that members having a similar condition and similar office, grade, rank, or rating receive similar medical retention decisions. Attorneys are also likely to benefit from classroom training, with proof of distance-learning certification, if classroom space is available.

Although PEBLOs and disability evaluation counselors require expertise in all of the DES topics recommended for classroom training, and some may wish to extend their expertise to this higher level required for adjudicating cases, the disability evaluation classroom training recommended here is not targeted to their specific performance needs. Rather, the classroom training is intended to develop the skills necessary for the PEB members and approving authorities and post-PEB appellate review board members to evaluate and adjudicate cases in a consistent manner across the military departments and for the Medical Evaluation Board members and approving authorities to apply disciplined medical retention standards uniformly such that members having a similar condition and similar office, grade, rank, or rating receive similar medical retention decisions. Satisfactory classroom performance can also serve as another aspect of certification.

Note that active and Reserve component commanders are not included in the classroom training because our analysis suggests that they benefit sufficiently from their self-directed computer-based distance-training packages.

In addition, numerous primary participants that we interviewed expressed concern about the difficulty both Medical Evaluation Board members and PEB members had in applying the many standards, rules, procedures, and other considerations consistently within military departments, let alone across military departments. Three issues of concern surfaced repeatedly during our interviews that reinforce the need for more-advanced classroom training to enable physicians and nonmedical PEB members, in particular, to apply disability policy consistently within and across military departments. The issues, as articulated most clearly and concisely by primary participants, are as follows:

1. Human elements such as emotions and personality traits, "good service member" versus "bad service member" issues, and the member's length of service—especially when nearing 20 years—hamper efforts to render fair and consistent decisions.
2. PEB decisions change noticeably with new members' differing personal philosophies.
3. Primary participants interpret DoD policy and apply it consistently to the best of their ability. However, primary participants do not converse with their counterparts from the other military departments or the OSD so they have no way of knowing if they are passing judgments that differ from their counterparts in the other military departments.

As a result, we recommend supplementing the DoD self-directed computer-based distance-training packages with DoD classroom training for PEB members and approving authorities, appellate review board members, and Medical Evaluation Board members and approving authorities across the military departments. The classroom training focuses on applying a particular set of DES topics to develop the skills necessary to evaluate and adjudicate cases and apply disability policy consistently across and within the military departments.

The classroom training is designed explicitly to supplement the self-directed computer-based distance training. As such, completing the appropriate distance-training package is a prerequisite for enrolling in classroom training, evidenced perhaps by a certificate of self-mastery of the required knowledge and skills. Learning objectives, content, and student learning evaluation differ from the distance-training package in that they focus on *applying* a particular set of the DES topics learned in the distance-training packages to a variety of real-life cases.

We refined the comprehensive list of DES topics, which are presented in Appendix G, to a shorter list of DES topics that form the basis for classroom-training content, as shown in Table 5.4. This set of DES topics enables students to practice applying the numerous standards, rules, procedures, and other considerations to a wide variety of

case studies in a controlled classroom environment in which students collaborate on making decisions that result in consistent dispositions.

The letters *A* and *B* in Table 5.4 are used to represent two logical training modules, one developed to present to primary participant population Cluster 2 and Cluster 3,[13] and the other presented only to population Cluster 3. The full range of information included within some DES topics appears in italics under the shaded entries.

Smaller class sizes are preferable for practicing case evaluation and adjudication. Given the pent-up need for this training and the frequency of primary participant turnover, we envision scheduling classroom training quarterly during the first and second years, and determining frequency for the outlying years based on the needs at the time.

As with the self-directed computer-based distance training, selecting experienced and credible subject-matter experts who are able to develop and deliver high-quality training that produces the desired on-the-job results from the populations trained is critically important. And as with distance training, these subject matter experts serve as adjunct faculty who are delegated the authority by the OSD to develop and deliver the DoD disability evaluation training.

And, like the recommended computer-based distance-training packages presented in Table 5.2, this classroom-training package is based on the system purpose and desired outcomes that inform the primary participant competencies proposed in this report. Also, like the distance-training packages, this classroom training package is a template, or starting point, for consideration by the Office of the ASD/FMP, in consultation with the ASD/HA and the ASD/RA, and representatives of the military departments' PEBs and Office of the Surgeons General.

If further OSD consultations with experienced DES experts result in changes to the purpose, desired outcomes, and/or primary participant competencies that serve to inform specific training content and packages, or changes to the content itself, the Office of the ASD/FMP should consider the merit of the changes and make the appropriate alterations. If a later assessment of training effectiveness demonstrates that PEBLOs or other primary participants require classroom training, then the Office of the ASD/FMP should modify the training packages to enable the primary participants to produce the desired on-the-job results.

Although training is often viewed as a cost of doing business, it should more appropriately be viewed as an investment. Training that enables each primary participant of the DES to produce desired on-the-job results using the knowledge and skills learned produces a return on that investment. Participants who continue to use the knowledge and skills they acquire through training represent a return that grows in value.

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[13]Primary participant population Cluster 2 includes physicians who write narrative summaries and Medical Evaluation Board members and approving authorities. Primary participant population Cluster 3 includes PEB members and approving authorities, post-PEB appellate review board members, and attorneys.

Table 5.4

Disability Evaluation System Topics Forming the Basis for Classroom Training Modules

	Primary Participant Populations					
Topic	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities
Fact versus opinion	A	A	A	A	A	A
Retention standards considered by Medical Evaluation Board	A	A	A	A	A	A
Compensability criteria	A	A	A	A	A	A
Proximate result	A	A	A	A	A	A
Presumptions of service incurred/aggravated and overcoming presumptions	A	A	A	A	A	A
Conditions presumed to be preexisting	A	A	A	A	A	A
Noncompliance (refusal of treatment)	A	A	A	A	A	A
Organization of the VASRD plus supplements (currently 26) and updates	A	A	A	A	A	A
Analogous codes in DoD Instruction 1332.39 that supplement the VASRD	A	A	A	A	A	A
Military department analogous codes that supplement the VASRD and DoD Instruction	A	A	A	A	A	A
Standards for determination of fitness	B	B	B			
Compensability criteria						
15-year rule for early qualification for retired pay for members of the selected Reserve	B	B	B			

Table 5.4—Continued

Topic	Primary Participant Populations					
	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities
Compensability standards						
Prior service impairments	B	B	B			
Reserve component performing duty of 30 days or less	B	B	B			
Adjudication of TDRL reevaluations	B	B	B			
Procedure for rating by analogy; use of hyphenated codes in disability adjudication	B	B	B			
What is required to increase percentage of disability determined by PEB	B	B	B			
Combined ratings/overall effects	B	B	B			
Bilateral factor	B	B	B			
Pyramiding	B	B	B			
Adjudication of cases involving mental disorders	B	B	B			
Administrative determinations for purposes of employment under federal civil service	B	B	B			
Administrative determinations for federal tax benefits	B	B	B			
Abuse of discretion	B	B	B			

In the next chapter, we describe a suggested structure for a management information system capable of monitoring DES performance (at the DoD, military department, and MTF levels), and Chapter 7 presents a cost-benefit analysis of the training intervention recommended here.

Chapter Six

MONITORING SYSTEM PERFORMANCE

Of the ten recommended interventions listed in Chapter 4, two have the greatest impact on system performance. One of them is, of course, training. The other is the development of a management information system. As stated previously in this report, we recommend that the ASD/FMP, in coordination with the ASD/HA and the ASD/RA, direct the Director of Officer and Enlisted Personnel Management to develop and maintain a comprehensive management information system that is capable of monitoring relevant performance measures.

Monitoring key performance measures (as they apply to both the active and Reserve components) enables the OSD and military department DES leaders to assess, analyze, and take action to continually improve the performance of the DES. Regularly reporting system performance to senior military department officials and the OSD in a valid and meaningful way is essential to the DES primary participants being able to carry out their responsibilities. This chapter outlines the specifications for just such a performance-monitoring system.

The military departments operate their DESs for the benefit of two customer groups: the service members and the individual military services. DES performance should be judged by how well it meets the expectations of these external customers. In turn, a stated system purpose and desired outcomes define customer expectations. Service member expectations center on similar dispositions for service members in similar circumstances and on due process, whereas military service expectations center on expeditious processing of disability cases and efficient DES operations.

We recommend that the OSD monitor a variety of performance measures. These measures encompass (1) perceptions that come directly from customers on how well the DES meets their expectations and (2) indirect, but more objective and quantitative, measures. The latter measures primarily include outcome and output measures augmented with one input measure[1] linked together in a framework that identifies the relationships among the measures and how they affect overall performance of the DES. *Outcome measures* include case variability, number of decisions appealed

[1] *Outcome measures* assess the results of a program or system compared with its intended purpose; they are lagging indicators of performance. These measures represent the quantitative manifestation of customer expectations. *Output measures* assess immediate performance results of key parts of a system that contribute to system outcomes. They are a mix of lagging and leading indicators of performance, where each indicator is linked to others in a logical way.

by service members, amount of time to replace an unfit service member, and total system cost. *Output measures* include percentage of primary participants certified, productivity, cost per case, average processing time, number of reworks, and amount of time to promulgate policy change. We suggest one *input measure*, total resources devoted to the DES. We suggest multiple metrics for each performance measure later in this chapter.[2]

To motivate the military departments to improve system performance, we recommend that the OSD benchmark metrics against trends, an OSD standard, and/or DoD averages. In addition, using the framework underlying the performance measures, the OSD should establish targets for key metrics and require the military departments to present a plan for how they are going to achieve the OSD targets over a specified time period, followed by a report of the military department's actual metrics at the end of the period.

Each military department plan should delineate specific actions to achieve the OSD key metric targets and its DES performance objectives for the specified period. Each military department performance report should communicate its performance (metrics) on the specified measures and its own performance objectives to the OSD at the end of the specified period.

Finally, we recommend summarizing the information that is gathered and analyzed and feeding it back to the primary participants of the DES.

To be most effective, performance monitoring must be results-oriented (and not focused on inputs or processes), built into the operational routines of the system, and reported frequently and publicly. On the other hand, monitoring performance is a waste of time if the information received is not evaluated and acted upon. The management information system recommended in this chapter provides the foundation for system performance evaluation and leadership action to establish such a management information system.

THE NEED FOR A MANAGEMENT INFORMATION SYSTEM

A management information system is essential to effectively carrying out the responsibilities assigned by DoD Instruction 1332.38. As the primary vehicle for providing feedback, this system is also critical to the success of training and other interventions recommended in previous chapters of this report.

Although DoD Instruction 1332.38 does not specifically mandate a management information system to carry out its directives, it does assign responsibilities we believe can only be effectively accomplished with input from such a system. In particular,

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[2]The terms we employ in this report form a hierarchical structure of increasing specificity. We start with the term *outcomes*. Outcomes are the system results of importance to external customers. We define them in terms of customer expectations. *Outcome measures* represent the quantitative manifestation of these expectations. Similarly, *output measures* represent the quantitative manifestation of intermediate results produced by the system. *Metrics* are more-quantitative representations of outcomes, outputs, and inputs—the actual data in the management information system.

Section 5.2.3 of DoD Instruction 1332.38 directs the ASD/FMP to "Establish necessary reporting requirements to monitor and assess the performance of the DES and compliance of the military departments with [DoDI 1332.38] and DoD Directive 1332.18." Section 5.2.7 further directs the ASD/FMP to "Develop quality assurance procedures to ensure that policies are applied in a fair and consistent manner." Section 5.5.2 directs the Secretaries of the military departments to "Establish a quality assurance process to ensure that policies and procedures established by [DoDD 1332.18 and DoDI 1332.38] are interpreted uniformly."

Unfortunately, the data required to fulfill these responsibilities are not currently available. The OSD gathers little data on the operation of the DES; the limited data focus on the amount of time taken to process medical boards and on the types of disabilities that are processed. The information collected is practically useless in assessing consistency of policy application. Among the military departments, the Army collects and analyzes the greatest amount of data; we applaud its plan to expand its data collection and analysis. Nevertheless, this is a situation that needs to be corrected at the OSD level if senior leadership is to meet its responsibilities for ensuring the consistent application of disability policy.

In addition to monitoring and assessing the degree to which the DES accomplishes its purpose while potentially serving as the basis for future interventions to improve performance, a management information system is needed to assess the effectiveness of the interventions we recommend in Chapter 4.

The analysis of the issues we identified through interviews with primary participants and by attending major military department training events served, in effect, as a surrogate for a more desirable and comprehensive analysis that would have been possible had a management information system that monitors outcome and output measures been in place. Although this analysis was an effective mechanism for identifying the most-obvious areas of concern, it does not allow for feedback with which to judge the effectiveness of the recommended interventions. Because the recommended interventions are based on information that is not necessarily complete, objective, and empirically based, we expect that the interventions are not as finely tuned as they otherwise might be.

A department-wide management information system can support the need for information to carry out the leadership responsibilities both in the OSD and in the military departments and evaluate and further tailor the recommended interventions. This chapter outlines the characteristics of such a management information system.

The following sections of this chapter focus on the question, how should the leadership of the DES assess the system's performance? The chapter then describes a framework relating major parts of the DES that, individually and in combination, influence system performance. Finally, in the context of this framework, this chapter delineates a set of specific metrics to collect, organize, and analyze in order to assess system performance.

ASSESSING THE PERFORMANCE OF THE DISABILITY EVALUATION SYSTEM

A management information system can provide data in many forms. The data of greatest interest in the context of this report are those that help the ASD/FMP, the ASD/HA, and the ASD/RA assess DES performance. Generally, a system's performance is best evaluated from the perspective of its external customers. Most of the primary participants with whom we spoke identified two primary external customers: the service members and the military services.

Although primary participants identified service members as customers of the DES, some suggested that service members abuse the system by manipulating its procedures to delay their return to duty or to maximize compensation for injury or disease. Although these kinds of behaviors undoubtedly exist, primary participants expressed confidence that the vast majority of service members just want the system to treat them fairly.

Indeed, from the military service's perspective, the basic purpose of the DES is to evaluate and remove service members who are unable to perform their duties so that unit commanders may requisition replacements who are able to perform those duties. In the broadest sense, the DES primarily serves the higher-level departmental objective of maintaining a fit and ready force.

For the task of designing a management information system, the stated DES purpose serves as a statement of external customer expectations regarding system performance. As noted in Chapter 3, we formulated the following proposed statement of purpose of the DES: to evaluate service members with potentially unfitting conditions in a fair, consistent, efficient, and timely manner and, likewise, to remove those unable to fulfill the duties of their office, grade, rank, or rating and determine a disability rating percentage for those removed. Chapter 3 also delineates five outcomes that elaborate on the stated purpose.

Table 6.1 portrays the relationship between the outcomes for the DES and customer expectations for those outcomes.

Table 6.1

Disability Evaluation System Outcomes and Customer Expectations

Outcomes	Expectations
Service members having a similar condition and similar office, grade, rank, or rating receive similar fitness decisions within the military department	Similar dispositions
Service members found unfit receive similar disability ratings for similar conditions across and within the military departments	Similar dispositions
Service members freely and appropriately exercise their rights to administrative due process	Due process
Service members return to duty, or separate or retire for disability in a timely manner	Expeditious processing
Primary participants perform their duties as efficiently as possible so that collectively they return service members to duty, or separate or retire service members in a fair, consistent, and timely manner	Efficient operations

The two customer categories (service members and military services) align nicely with these customer expectations.[3] In particular, fair and consistent treatment primarily reflects how well the DES fulfills the expectations of service members. This means the system fulfills service member expectations when

- service members in similar circumstances with similar conditions receive similar dispositions (fitness, disability rating, and personnel actions)
- service members are afforded administrative due process (namely, they receive the information they need to make informed decisions and to evaluate the decisions rendered by the system, and they receive the opportunity and resources for appeal to address reasonable concerns).

Expeditious processing and efficient operations primarily reflect how well the DES fulfills the expectations of the services. This means the system fulfills service expectations when

- primary participants process medical boards according to explicit time standards
- primary participants utilize "best business practices" to meet standards and honor service member expectations.

The OSD and the military departments can and should assess system performance directly in terms of how well service members, commanders, and other senior leaders perceive that the system meets their expectations. In particular, audit and survey instruments (such as Inspector General reviews and OSD surveys) can assess service members' perceptions of fairness and due process.

Service members' perceptions are naturally inherent in each service member; the accuracy or validity of the perceptions does not necessarily affect whether the service member believes the system fulfilled his or her expectations. Nevertheless, these audit and survey instruments can inquire about sources of satisfaction and dissatisfaction with the system as it relates to the service member's expectations.[4] Similarly, the OSD can assess how well the DES fulfills the expectations of the services by observing the numerous mechanisms (personal communications, leadership direction documents, budgets, and other information) that commanders and other senior leaders use to express formally and informally their satisfaction or dissatisfaction.[5]

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[3]This is not to suggest that the two types of customers are concerned solely with their respective expectations, but rather that the expectations characterize the primary interests of each category. That is, the service members' expectations center around outcomes that lead to similar dispositions and their right to due process, and the military departments' expectations center around expeditious processing and efficient operations of the system.

[4]Performance measures that focus on fair treatment of the service member could supplement the surveys, and perhaps highlight where perceptions differ from the facts. Personal perceptions, in the end, however, are likely to be the primary determinants of whether the member believes his or her expectations are fulfilled or not.

[5]In addition, we recommend that the DoD Inspector General periodically assess how closely the military departments are following the directions in the DoD Instruction. For example, the DoD Instruction currently directs the PEB to include its rationale for the fitness determination in its report. However, primary participants reported that this direction was not being followed and, as a result, disability policy

Relying on the perceptions of customers has certain advantages. In fact, customer perceptions constitute an important component of the management information system this chapter describes. Reliance on customer perceptions falls short, however, in terms of providing leadership with the full range of information it needs to carry out its assigned responsibilities. Therefore, we recommend a set of complementary measures, although as proxies only, that provide a more objective and quantitative indication of how well the DES fulfills customer expectations.

These complementary measures comprise two types: outcome measures and output measures, as defined earlier in this chapter. Outcome measures provide the best insight into the operation of the system as a whole, but they are less helpful in determining the effect of interventions on the performance of the DES. Outcome measures have their genesis in the four customer expectations listed in Table 6.1. Output measures, on the other hand, provide insight into the operation of major parts of the DES. Output measures lack the comprehensiveness of outcome measures but provide significantly more insight into the effect of interventions on system performance.

Both types of measures, however, directly or indirectly reflect how well the DES fulfills the performance expectations of external customers. The remainder of this section discusses outcome measures (because they are most closely related to customer expectations); the next section of this chapter discusses output measures in more depth.

Two outcome measures of system performance—*case variability* and *number of appeals*—capture critical aspects of service member expectations (that is, similar dispositions and due process). Case variability is an indicator of consistency in the system. If the system treats similar service members with similar disabilities in similar ways, we consider the system to be consistent in its operation.[6] The number of appeals is, admittedly, a very gross proxy for due process. Appeals, however, can signal a lack of confidence in the system (service members questioning every determination), or alternatively, that the system is operating as intended (by affording service members the opportunity to exercise their rights). Consequently, this measure is preliminary and potentially suggestive of problem areas, not a hard indicator of how well the system is performing with regard to due process. We recommend a combination of metrics,[7] which are discussed later, to provide greater insight into this aspect of service members' expectations.[8]

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was being inconsistently applied. In this particular situation, inappropriate considerations (such as those based on personal bias) would be more difficult to employ if the direction were followed.

[6]We recommend that the DoD Inspector General periodically sample completed cases and assess the similarity of final dispositions (fitness, ratings, personnel action) for similarly situated service members (within and across military departments). These surveys differ from the "customer satisfaction" surveys that focus on service member *perceptions* of whether the system fulfilled the member's expectations (and, as noted earlier, could provide a basis for comparing perceptions with the facts).

[7]The report uses the term "metrics" to mean the specific data to collect, organize, and store in the management information system. Several metrics may be associated with a specific outcome or output measure.

[8]Based on our review of the system, we found no indication that service members were being denied due process. This appears to be a major example of a part of the DES that is working effectively. However, be-

Two other outcome measures of system performance—*time to replace "broken" service members*[9] and *total cost of the system*[10]—capture critical aspects of service expectations (that is, expeditious processing and efficient operations). Time to replace a service member is an important measure from the perspective of unit commanders. The less time between the onset of an injury or disease that adversely affects a service member's unit performance and the arrival of a replacement, the better the DES meets the unit commander's expectation. The lower the total cost of the system (the denominator in an assessment of efficiency), the better the system meets the service's expectation.

Figure 6.1 portrays the relationship between the proposed purpose of the DES and customer perspectives and expectations, and the relationships between customer expectations and the suggested outcome measures, as discussed in this section.

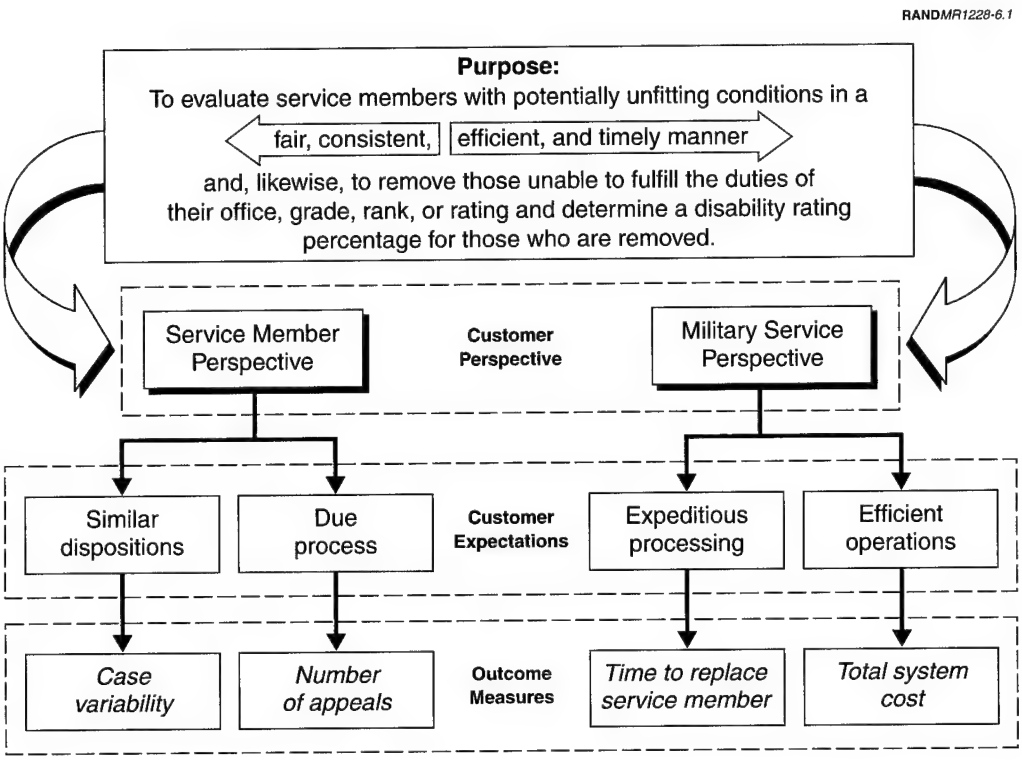

Figure 6.1—Proposed Purpose of the Disability Evaluation System Linked to Suggested Outcome Measures

cause due process is a critical element of overall system performance, it is an aspect that requires constant vigilance. This is one reason that we believe it should have a central role in the purpose statement and in the measures used to assess system performance.

[9]This term refers to service members who are under a physician's care and unable to perform their normal duties, and service members who are deemed unfit by the PEB to perform the duties of their office, grade, rank, or rating.

[10]Total cost of the system includes the variable costs of operating the DES plus investments in training and automation. Although not visible in the budget process, investments in training and automation should be amortized and future benefits included in the cost perspective.

Unfortunately, by their nature, outcome measures (and, direct measures of customer perceptions) are lagging indicators of system performance. Monitors cannot determine how well a program or system is performing until after the fact. Although they are useful in hindsight and in the final determination of performance, outcome measures are less-than-desirable measures for ensuring desired results.

Identifying and acting on leading indicators are key actions to ensure desired system results as required by the responsibilities assigned in DoDI 1332.38. Consequently, we propose an expanded set of performance measures that encompass leading indicators by measuring system outputs. Output measures reflect intermediate performance results of key parts of the system that contribute to system outcomes. Output measures also reflect a mix of lagging and leading indicators, where each indicator is linked to the other indicators in a logical way. The following describes an integrated set of performance measures for assessing how well the DES accomplishes its purpose. Performance measures include both outcome and output measures.

DEVELOPING AN INTEGRATED SET OF PERFORMANCE MEASURES

To guide our search for leading indicators of system performance, we asked two fundamental questions: (1) What moves lagging indicators in the right direction? and (2) What can those charged with overseeing the system control and be held accountable for that will lead to the desired outcomes? To answer these questions, we identified output measures that, on the one hand, interventions can influence and, on the other, can lead to changes, directly or indirectly, in the outcome measures.

Two types of interventions significantly affect output measures: *process improvements* and *enhanced primary participant competence.*[11] Process improvements lead to faster cycle times that affect how quickly a case is resolved and impact how well the DES fulfills both service member and service expectations. Enhanced primary participant competence also supports faster cycle times by increasing productivity. In addition, it leads to reduced operating costs and better-educated commanders and service members who then become more-effective participants in the DES.

Figure 6.2 portrays the multiplicity of relationships among interventions, output measures, and outcome measures.

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[11]In other words, interventions in the form of process improvements and enhanced staff competency are actions that *lead to* specific changes in system performance that affects how well the DES is fulfilling both military service and service member expectations. To put it another way, the goal of a strategy for improving the operation of the DES is to better achieve the purpose of the system; two means for achieving that end are process improvements and enhanced staff competency.

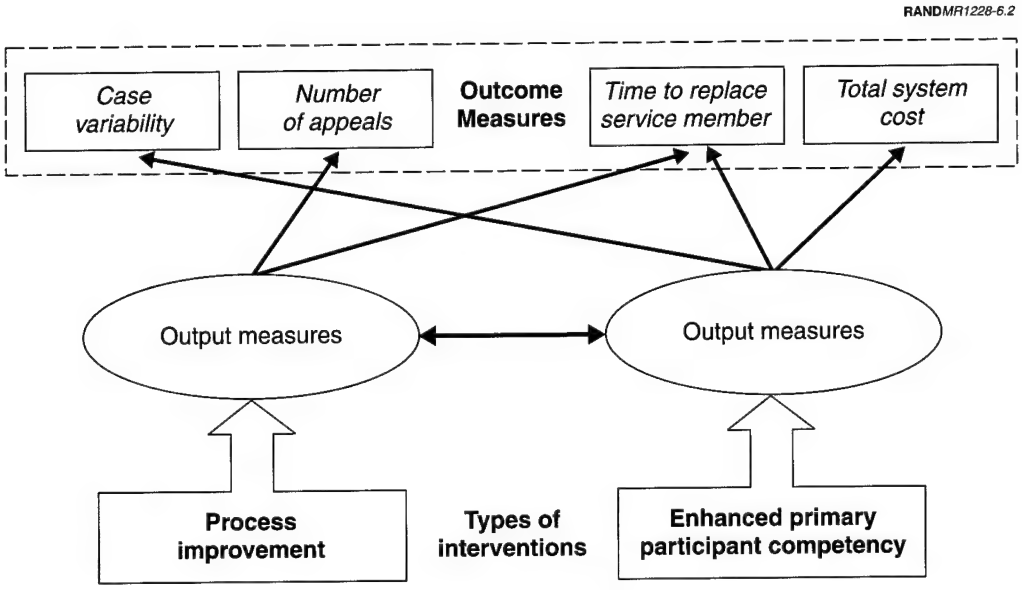

Figure 6.2—Linking Interventions to Outcome Measures Through Output Measures

Process Improvements Intervention

The OSD can assess the impact of the majority of process improvements by focusing on three output measures: *processing time, number of reworks,* and *time to promulgate policy change.* Processing time is the length of time it takes a service member represented by a medical board, to proceed through the various phases of the DES. Processing time focuses more narrowly than the outcome measure *time to replace,* in that it focuses attention on what parts of the DES contribute most to the overall time-to-replace outcome measure. Although the number of reworks (for example, instances in which medical boards are referred back to an earlier phase in the process for lack of information) affects the processing time, it is a major source of delay and, therefore, deserves specific attention. The time a military department takes to promulgate policy change or guidance also affects the consistency of policy application, particularly across military departments.[12]

Enhanced Primary Participant Competency Intervention

The OSD can assess the impact of the majority of actions directed at enhanced primary participant competency using three output measures: (1) productivity (medical boards processed per capita), (2) processing cost per medical board, and (3)

[12]One military department has not yet published a formal regulation incorporating changes in DoD Instruction 1332.38 published in 1996, though it has distributed memoranda that broadcast the changes. Although the operation of the military department DES conforms to the guidance contained in the DoD Instruction, primary participants and other interested parties rely on the outdated (circa 1990) implementing regulation for reference, which could be the source of incorrect information leading to variability in processing medical boards and implementing DoD disability policy.

percentage of primary participants certified, augmented with one input measure—total resources devoted to the DES.

Productivity is an important measurement of the contribution of different primary participants to system performance including PEBLOs, members of the Informal PEB and Formal PEB, PEB administrative action officers, and others.

Productivity and total resources affect the cost per medical board; however, the cost-per-medical-board measure provides greater insight into changes to the total cost of the system than do the other measures.

Certification is a key indicator of primary participant competency and one of the most useful of the output measures.[13]

Total resources devoted to the DES include manpower numbers and cost, information support, training, and operation and maintenance funds (other than for civilian salaries and training). A measure of total resources focuses attention on the fundamental level of input into the DES.

A Framework for Integrating Outcome and Output Performance Measures

Arguably, the output measures associated with process improvements and enhanced primary participant competency are leading indicators of system performance. For example, as productivity increases, processing time and the time to replace a service member found unfit decreases. It may take a while, however, for outcome measures to reflect productivity increases. Similarly, as the percentage of primary participants who are certified in their particular body of DES knowledge and skills that are required to produce desired on-the-job results increases, service members receive better information, make more-informed appeals, and more-positively assess how well the DES fulfilled their expectations, in addition to other benefits.

We constructed a framework of hypothetical relationships among the system performance measures, which is shown in Figure 6.3. A similar or opposite impact that a change in one performance measure has on another performance measure is denoted in the figure with a plus or minus sign. For example, the plus sign next to the arrow pointing upward from "Total Resources" in the figure suggests that as total resources increase, the percentage certified also increases (that is, the measure moves in the same direction). Conversely, the minus sign next to the arrow pointing to the left of Total Resources suggests that as total resources increase, the time to promulgate policy change does just the opposite; that is, it decreases. Consequently, as the time to promulgate policy change decreases, case variability also decreases (that is, it moves in the same direction, as noted by the plus sign).

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[13]The objective of a certification process is to produce a fully capable human resource. Certification might consist solely of evidence of training, or evidence of training plus some amount of experience; it might also entail evidence of periodic continuing education. There might also be a different certification process for each primary participant population (for example, for physicians being certified in writing narrative summaries and PEBLOs being certified in their much broader body of DES knowledge).

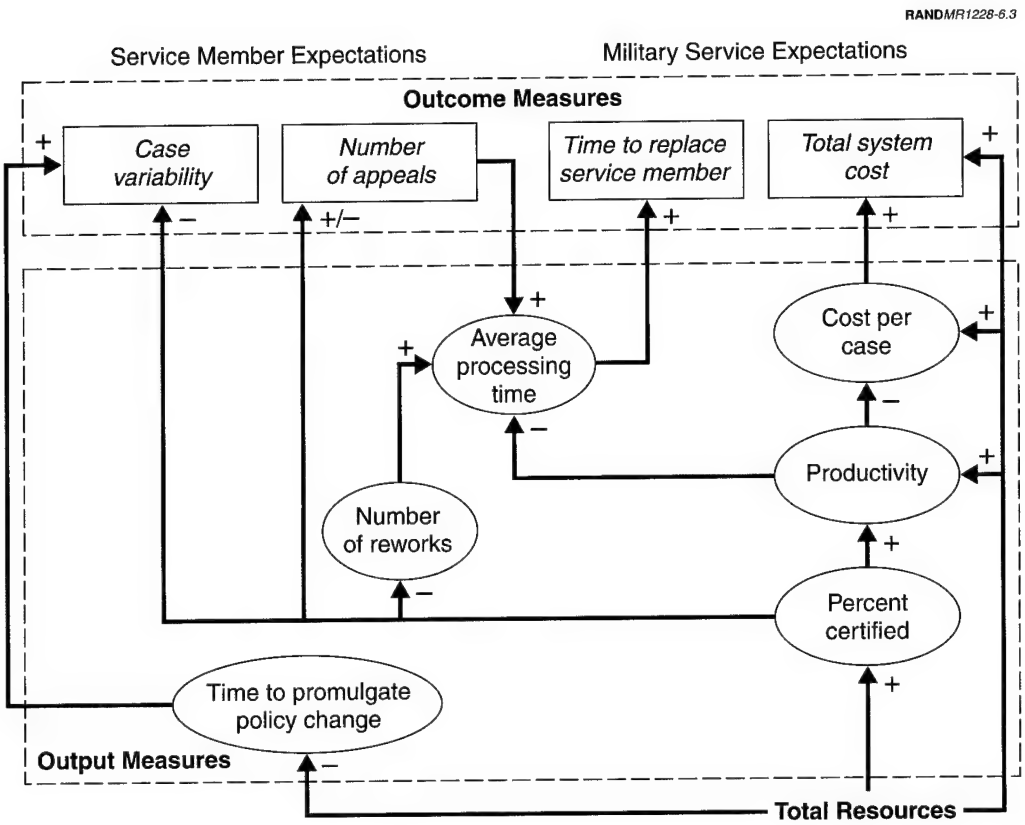

Figure 6.3—Effect of a Change in One Performance Measure on Another Performance Measure

As noted earlier in this chapter, the number of appeals is a very gross proxy for due process, an outcome measure related directly to service member expectations. We indicate the ambiguity of this measure with a plus/minus sign next to "Number of Appeals" in Figure 6.3.[14]

Figure 6.3 highlights the central role that certification plays in the overall performance measurement process. It influences, directly or indirectly, nearly every other performance measure. Only the level of total resources, an input into the system, is more influential. The primacy of certification in relation to the other measures of system performance is congruent with the emphasis we place on the training intervention in Chapter 5. Figure 6.3 also suggests that a decrease in resource allocations would produce results that are different from those we just described. The figure also identifies where to focus attention to measure system performance in order to determine if the level of resources produces the intended result.

[14]An increase in the percentage certified could lead to an increase in the number of appeals (for example, as a result of increased service member awareness) or to a decrease in the number of appeals (for example, as a result of acquiring more information regarding the conditions under which an appeal would be granted).

Based on our review of the DES and our conversations with many of its primary participants, these performance measure relationships have face validity. As noted earlier, the OSD should treat the relationships illustrated in the figure as hypothetical ones. The validity of these interrelationships will emerge over time; if they do not prove to be accurate, or if other aspects of the DES increase in importance, the OSD should revise the measures and relationships portrayed in Figure 6.3. Revising performance measures and the relationships among measures as needed is a critical part of monitoring the system over time, in accordance with the responsibilities assigned by DoD Instruction 1332.38.

Focusing solely on outcome measures puts the DES leadership in the position of reacting to unfavorable results only after the fact. In this case, leadership lacks information to assess whether the interventions that were employed to maintain or improve certain results were inadequately deployed or were the wrong interventions altogether. The framework illustrated in this section is a strategic performance management tool for carrying out the responsibilities assigned by DoD Instruction 1332.38 and for identifying areas that deserve increased attention and focus,[15] with the intent of better achieving the purpose of the Disability Evaluation System, and not acting as a report card.[16]

IMPLEMENTING A MEASUREMENT SYSTEM

Most of the performance measures described in this chapter have multiple dimensions. To capture the richness underlying these measures, and thereby create a complete picture of system performance to identify potential problems quickly enough to take corrective action and assess the impact of the interventions, we recommend a number of metrics for each performance measure. These metrics are summarized in tabular format at the end of this chapter; a detailed narrative description appears in Appendix H.

General Observations

We begin with some general observations regarding the metrics.

First observation: A performance measurement system requires a sizable collective effort and a significant amount of resources. For a performance measurement system to be effective, OSD and military department leadership must commit to providing the resources—monetary, work force, and collection method resources—needed to obtain the data with which to compute the metrics used to monitor the

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[15]To be most effective, a review of performance measures such as that outlined in this section should involve senior civilian and military officials from the military departments, and not just the primary participants of the DES. To carry out its responsibilities, senior leadership should use the framework suggested here and modify that framework if it is found to be ineffective in explaining the effects of major interventions.

[16]It is important to note that this framework is not the means for evaluating individual primary participants or even a military department's DES. Rather, it is a device for focusing attention on and monitoring the critical performance measures and holding the appropriate primary participants or military department accountable for change in the right direction for each performance measure.

system. Ideally, the administrators of the DES (PEBLOs, disability evaluation counselors, patient administrators, and PEB action officers) enter the data into an automated system designed to monitor performance. Many of the metrics recommended in this report are suited for this method of collection. Designing an automated management information system requires early decisions on the form and content of the data the military departments will collect and provide to the OSD.

In the absence of an automated system, to ease the burden on administrative personnel and increase the availability and accuracy of the data collected, we recommend that the ASD/FMP direct the Director of Officer and Enlisted Personnel Management to consult with a small group of experienced DES experts representing the military departments' PEBs and the Office of the Surgeons General to *decide* on the design of a common hard copy form for gathering and recording the data. Because the medical board is the central administrative element around which the DES operates, we envision attaching this form to the front of the medical board. The form will contain data already part of, or that can be derived from, the medical board; regardless, the intent is to consolidate the collected data in an easily accessible location, such as the front of the medical board.

Second observation: To motivate DES performance improvement in the military departments, we recommend that the OSD establish benchmarks for key metrics based on trends, a DoD standard, and/or DoD averages. Most of the metrics proposed in the following section are based on historical data. Consequently, for most of the metrics, the appropriate benchmark is the trend that the metric exhibits over time (that is, a self-improvement benchmark) or how the metric compares with a DoD standard or to the average value of the metric across the DoD as a whole (that is, a comparative benchmark). Although a trend does not constitute a firm benchmark to strive for, it can highlight a change in the direction of DES performance and can be the basis for continued improvement. Significant changes in a trend or significant deviation from the DoD standard or average should initiate investigation into the cause of the changes.

Importantly, the framework portrayed in Figure 6.3 lends itself to developing and specifying OSD performance objectives for succeeding time periods to achieve the set of desired outcomes.[17] For explicit OSD performance objectives, the OSD should require the military departments to present a plan for achieving the OSD objectives over a specified time period. This plan should delineate the specific interventions to be made and the military department performance objectives to be achieved for each performance measure during that period. The collection of metrics reported in each period describes the actual performance of the military department over time; the military department plan sets the desired performance for the future.

On the one hand, an explicit plan is a means by which the OSD holds the Secretaries of the military departments accountable for achieving the DES's stated purpose. On the other hand, it is the means by which the officials responsible for the DES in each

[17]Processing times are an example of current targets set by the OSD.

military department can articulate a case for the resources needed to achieve the desired outcomes.

Third observation: Based on our conversations with a wide range of primary participants, we concluded that a major source of variability in the system arises from the lack of information within the system about how the system is operating. We strongly recommend summarizing the performance data gathered and analyzed and feeding it back to the primary participants of the DES. Regularly reporting DES performance results to senior officials in the military departments and the OSD in a valid and meaningful way is, also, essential to enable them to carry out their responsibilities.

To be most effective, performance monitoring must be results-oriented (and not *focused* on inputs or processes), built into the operational routines of the system, and reported frequently and publicly. However, in and of itself, monitoring performance is a waste of time if the information received is not evaluated and acted upon. The outcomes, performance measures, and metrics recommended in this chapter provide the foundation for evaluating and acting.

A Set of Metrics

We recommend that the OSD direct the military departments to collect, analyze, and submit the metrics outlined in Tables 6.2 through 6.5. Each performance measure—outcome, output, and input—encompasses several metrics. The metrics listed in Tables 6.2 and 6.3 focus on the *outcome measures* directly related to the assessment of how well the DES fulfills military service and service member expectations. The metrics listed in Tables 6.4 and 6.5 focus on the *output measures* related to the two interventions, process improvements and enhanced primary participant competency.

The following tables briefly summarize each metric, the metric's reporting frequency, the data source, comparative benchmark, and the mechanism for gathering the data. Appendix H contains a more detailed description of these metrics.

Table 6.2

Performance Metrics for Assessing Service Member Expectations

Metric	Frequency	Data Source	Benchmark	Data-Gathering Mechanism
		Case Variability		
Distribution of medical boards by diagnostic category	Quarterly	Medical Boards forwarded to Informal PEB (IPEB) in previous quarter	Trends	Data collection sheet attached to medical board
Statistical analysis of dispositions (fitness, rating, personnel action) for major diagnostic categories	Annual	Random sample of PEB decisions rendered from the top five diagnostic categories in the previous year	Trends, DoD standards	Sample survey

Table 6.2—Continued

Metric	Frequency	Data Source	Benchmark	Data Gathering Mechanism
Statistical analysis of dispositions (fitness, rating, personnel action) for special diagnostic categories (e.g., HIV)	Annual	Random sample of PEB decisions rendered from the special diagnostic categories in the previous year	Trends, DoD standards	Sample survey
		Number of Appeals		
Percent of IPEB decisions appealed for fitness	Quarterly	IPEB decisions rendered in the previous quarter	Trends, DoD average	Data collection sheet attached to medical board
Percent of IPEB decisions appealed for fitness overturned	Quarterly	IPEB decisions rendered in the previous quarter	Trends, DoD average	Data collection sheet attached to medical board
Percent of IPEB decisions appealed for rating	Quarterly	IPEB decisions rendered in the previous quarter	Trends, DoD average	Data collection sheet attached to medical board
Percent of IPEB decisions appealed for rating overturned	Quarterly	IPEB decisions rendered in the previous quarter	Trends, DoD average	Data collection sheet attached to medical board
Percent of Formal PEB (FPEB) decisions appealed for fitness	Quarterly	FPEB decisions rendered in the previous quarter	Trends, DoD average	Data collection sheet attached to medical board
Percent of FPEB decisions appealed for fitness overturned	Quarterly	FPEB decisions rendered in the previous quarter	Trends, DoD average	Data collection sheet attached to medical board
Percent of FPEB decisions appealed for rating	Quarterly	FPEB decisions rendered in the previous quarter	Trends, DoD average	Data collection sheet attached to medical board
Percent of FPEB decisions appealed for rating overturned	Quarterly	FPEB decisions rendered in the previous quarter	Trends, DoD average	Data collection sheet attached to medical board
		General		
Percent of service members satisfied with disposition decision	Annual	PEB and appellate review board decisions rendered in previous year	Trends, DoD standards	100-percent paper survey
Percent of service members satisfied with process (timeliness, courtesy, responsiveness, assistance)	Annual	PEB and appellate review board decisions rendered in previous year	Trends, DoD standards	100-percent paper survey
Percent of service members satisfied they received due process	Annual	FPEB decisions rendered in previous year	Trends, DoD standards	100-percent paper survey
Number of congressionals	Annual	Correspondence control	Trends, DoD average	Review of correspondence records
General Accounting Office reports	When issued	Report	Internal to report	Review of report
Inspector General reports	When issued	Report	Internal to report	Review of report

Table 6.3

Performance Metrics for Assessing Military Service Expectations

Metric	Frequency	Data Source	Benchmark	Mechanism
		Total System Cost		
Total resources for the operation of the DES	Annual	Budget data	Trends	Budget analysis
Pay and allowances for service members not performing duty	Annual	Budget data	Trends	Budget analysis
The cost of disability severance pay	Annual	Budget data	Trends	Budget analysis
		Time to Replace		
For service members returned to duty, average total time from referral to an MTF to return to duty, broken out by diagnostic category	Quarterly	Medical boards of service members returned to duty in the previous quarter	Trends	Data collection sheet attached to medical board
For service members separated or retired, average total time from referral to an MTF to termination, broken out by diagnostic category	Quarterly	Medical boards of service members terminated in the previous quarter	Trends	Data collection sheet attached to medical board
Average total time on the TDRL, broken out by diagnostic category	Quarterly	Medical boards of service members removed from the TDRL in the previous quarter	Trends in average time	Data collection sheet attached to medical board
Average total time on limited duty, broken out by time before referral to the DES and after referral and by diagnostic category	Quarterly	Medical boards of service members referred to the DES and removed from limited duty in the previous quarter	Trends in average time	Data collection sheet attached to medical board

Table 6.4

Performance Metrics for Assessing Process Improvements

Metric	Frequency	Data Source	Benchmark	Mechanism
		Processing Time		
Distribution of waiting times for narrative summary dictation (referral to MTF to medical board dictated or service member returned to duty) by diagnostic category	Quarterly	Medical boards forwarded to IPEB in previous quarter	Trends, DoD standards	Data collection sheet attached to medical board
Distribution of waiting times for IPEB consideration (narrative summary dictated to IPEB recommendation) by diagnostic category	Quarterly	IPEB decisions rendered in previous quarter	Trends, DoD standards	Data collection sheet attached to medical board

Table 6.4 (continued)

Metric	Frequency	Data Source	Benchmark	Mechanism
		Processing Time		
Distribution of waiting times for FPEB consideration (IPEB recommendation to FPEB decision) by diagnostic category	Quarterly	FPEB decisions rendered in the previous quarter	Trends, DoD standards	Data collection sheet attached to medical board
Distribution of waiting times for completion of appellate review boards (FPEB decision to final appellate review board decision) by diagnostic category	Quarterly	Post-PEB appellate review board decisions rendered in the previous quarter	Trends, DoD standards	Data collection sheet attached to medical board
		Number of Reworks		
Percent of deficient commanders' letters at IPEB, by reason	Quarterly	Medical boards received by the IPEB in the previous quarter	Trends	Data collection sheet attached to medical board
Percent of deficient commanders' letters at FPEB, by reason	Quarterly	Medical boards received at the FPEB in the previous quarter	Trends	Data collection sheet attached to medical board
Percent of deficient narrative summaries at IPEB, by reason	Quarterly	Medical boards received at the IPEB in the previous quarter	Trends	Data collection sheet attached to medical board
Percent of deficient narrative summaries at FPEB, by reason	Quarterly	Medical boards received at the FPEB in the previous quarter	Trends	Data collection sheet attached to medical board
Percent of incomplete medical boards at IPEB, by reason	Quarterly	Medical boards received by the IPEB in the previous quarter	Trends	Data collection sheet attached to medical board
Percent of incomplete medical boards at FPEB, by reason	Quarterly	Medical boards received by the FPEB in the previous quarter	Trends	Data collection sheet attached to medical board
Time to transmit information to the field	When issued	Notification of policy implementation	Trends, DoD average	Confirmation memo from military department Secretariat
Time to update military department policy statements	When issued	Notification of policy implementation	Trends, DoD average	Confirmation memo from military department Secretariat
Time to update training	When issued	Notification of policy implementation	Trends, DoD average	Confirmation memo from military department Secretariat

Table 6.5

Performance Metrics for Assessing Enhanced Primary Participant Competencies

Metric	Frequency	Data Source	Benchmark	Mechanism
Productivity (Boards Per Capita)				
Medical board decisions rendered per IPEB member	Quarterly	IPEB decisions rendered in previous quarter; average number of IPEB members	Trends, DoD average	Data collection sheet attached to medical board
Medical board decisions rendered per FPEB member	Quarterly	FPEB decisions rendered in previous quarter; average number of FPEB members	Trends, DoD average	Data collection sheet attached to medical board
Medical board processing completed per full-time PEBLO and PEB Administrative Action Officer assigned to PEB	Quarterly	Total medical boards processed in previous quarter; average number of full-time PEBLOs and PEB Administrative Action Officers assigned to PEB	Trends, DoD average	Data collection sheet attached to medical board
Primary participant satisfaction, by primary participant population	Annual	Survey of primary participants	Trends	100-percent paper survey
Turnover, by primary participant population	Annual	Percent of participants remaining at end of year who began year	Trends	Manning documents
Cost Per Medical Board Decision				
Total system cost divided by total medical board decisions rendered	Annual	Budget data; medical board decisions rendered in the previous year	Trends	Budget analysis; data collection sheet attached to medical board
Percent of Primary Participants Certified				
Percent of commanders' letters submitted by certified commander	Quarterly	Commanders' letters forwarded to IPEB in previous quarter	Trends, DoD standards	Data collection sheet attached to medical board
Percent of medical boards dictated by certified physician	Quarterly	Medical boards forwarded to IPEB in previous quarter	Trends, DoD standards	Data collection sheet attached to medical board
Percent of PEBLOs certified	Quarterly	Personnel records	Trends, DoD standards	Personnel records
Percent of IPEB members certified	Quarterly	Personnel records	Trends, DoD standards	Personnel records
Percent of FPEB members certified	Quarterly	Personnel records	Trends, DoD standards	Personnel records
Percent of PEB administrative action officers certified	Quarterly	Personnel records	Trends, DoD standards	Personnel records

Table 6.5 (continued)

Metric	Frequency	Data Source	Benchmark	Mechanism
		Total Resources		
Number of individuals, broken out by DES phase and primary participant population, devoted to the DES	Annual	Budget data	Trends	Budget analysis
Pay and allowances/ salaries of individuals broken out by DES phase and primary participant population, devoted to the DES	Annual	Budget data	Trends	Budget analysis
Information management system costs	Annual	Budget data	Trends	Budget analysis
Training costs	Annual	Budget data	Trends	Budget analysis
Operations and maintenance costs (other than training and civilian salaries)	Annual	Budget data	Trends	Budget analysis

As discussed in Chapter 5, we recommend that the Office of the Assistant Secretary of Defense develop and monitor two methods of knowledge-based training—self-directed computer-based distance training and classroom training. Although training is often viewed as a cost of doing business, it can be more appropriately characterized as an investment that will reap benefits, both quantifiable and nonquantifiable, over time.

Also, as discussed in Chapter 6, certification—a measure of a primary participant's capability to produce the desired on-the-job results—influences a number of the DES outcome measures. For instance, we hypothesize that training will increase productivity and decrease the number of reworks, thereby decreasing the time to replace a member (a quantifiable benefit) and decreasing case variability (a non-quantifiable benefit).

Over the five-year time frame of the cost/benefit projection shown in Table 7.1, the quantitative benefits outweigh the costs by approximately $2.39 million. As shown in the table, during the development year, costs outweigh benefits, assuming Year 0 will be dedicated to developing the training packages. During Year 1 of the training, costs again outweigh the benefits. However, the benefits outweigh the costs in each of the remaining years (as reduced costs reflect the impact of shorter processing times).

Table 7.1

Net Present Value Quantifiable Costs and Benefits

Year	NPV Costs	NPV Benefits	NPV Total
0	$656,419	—	($656,419)
1	$2,997,861	$2,494,485	($503,376)
2	$2,518,245	$3,497,192	$ 978,947
3	$2,353,500	$3,268,404	$ 914,904
4	$2,199,532	$3,054,583	$855,050
5	$2,055,638	$2,854,750	$799,113
Total	$12,781,195	$15,169,414	$2,388,219

In addition to the $2.39 million in quantifiable benefits that training produces, it also produces the nonquantifiable benefits[1] of consistent policy application, increased job and customer satisfaction, and increased unit readiness.

This chapter presents our analysis of the costs and benefits of our training recommendations. Although *ex ante* cost-benefit analyses[2] provide useful information that can be used when deciding whether to undertake a project, they are based on *estimates* of the future costs and benefits. Whether or not the estimates hold in the future, the process of conducting cost-benefit analyses has high value in and of itself, as it helps leaders think in depth about specific projects and their associated results. We begin this chapter with a discussion of general assumptions underlying this analysis. We then present a detailed discussion of the costs and benefits of our training recommendations and conclude with a presentation and discussion of the results of the analysis.

GENERAL ASSUMPTIONS

Ex ante analyses are by necessity based upon a number of assumptions due to uncertainty regarding future results. We use the following assumptions throughout our entire analysis. Specific assumptions regarding the quantification of costs and benefits are discussed in the cost and benefit sections that follow this list of assumptions.

- A real discount rate of 7 percent is used in present-value calculations in accordance with Office of Management and Budget Circular A-94 guidelines.
- All costs and benefits are expressed in fiscal year 2000 real dollars.
- We count only the costs and benefits of the military departments and the OSD in this analysis.
- We assume a five-year time horizon for the training. We chose a five-year time frame for the lifetime of the training intervention, a relatively short time frame, for two reasons. First, because of the rapid changes in computer technology and current trends toward infinite bandwidth with negligible costs, it is likely that the OSD will choose to update and modernize its self-directed computer-based distance training significantly within the next decade. Second, in interventions such as this one that have up-front costs with benefits that accrue in later years, shorter time horizons place heavier emphasis on the costs of the intervention than on its benefits. In this analysis, we select a shorter time horizon in order to provide a conservative estimate of the impact of our recommended training.
- Fiscal year 2000 regular military compensation pay-grade averages are used to compute average daily pay figures for military personnel, both primary partici-

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[1]Technically, analysts could attempt to place monetary values on these benefits through contingent valuation techniques whereby willingness to pay for the benefit is elicited through survey techniques.

[2]An *ex ante cost-benefit analysis* occurs before a policy or program is in place and can assist in the decision about whether resources should be allocated to that program.

pants and service members progressing through the system. Average daily pay figures for military personnel reflect a 365-workday year.

- Civilian standard composite pay rates by grade are used to compute the average daily pay figures for civilian personnel.[3] Average daily pay figures for civilian personnel reflect a 260-day work year.
- We did not assume any quantifiable benefits or costs from increased consistent application of disability policy, specifically fitness and ratings decisions, within and among the military departments. We believe benefits will accrue from increased consistent application as a result of the training recommendations; however, within the scope of the study, we did not attempt to gather any data regarding the degree or impact of inconsistent fitness and rating decisions.

COSTS

We estimate that the net present value (NPV) of the cost of the training recommendations is $12.8 million over six years. This figure includes the cost of self-directed computer-based distance training and classroom training.

To estimate the cost of the training interventions, we made assumptions about training development and delivery details, such as the number of individuals developing training and the length and frequency of training for both the self-directed computer-based distance training and the classroom training. Table 7.2 details the assumptions upon which the cost analysis is based.

Cost of Self-Directed Computer-Based Distance Training

We estimate that self-directed computer-based distance training will cost $10.55 million over the five-year period. Table 7.3 details the cost of this training for the participants from each military department.

The vast majority (94 percent) of the cost of self-directed computer-based distance training is the opportunity cost of the participants who are engaging in the training. Appendix I provides data that show these opportunity costs broken down by military department and training population.

We do not include computer costs because we assume that every trainee will have access to an existing computer.[4] If this assumption proves to be false, an additional cost will accrue.

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[3]Fiscal year 1999 data were inflated by 3.8 percent to provide fiscal year 2000 estimates.

[4]We based this assumption on information we received during interviews with DES primary participants.

Table 7.2

Training Assumptions for the Two Methods of Knowledge-Based Training

Assumption	Self-Directed Computer-Based Distance Training	Classroom Training
Development time[a]	Initial: five months Yearly updates: one week	Initial: one month Yearly updates: one week
Internal developers	Three subject matter experts	Three subject matter experts
External developers	Web-based training developer	None
Training population	All primary participants	Fifty participants per session—primarily PEB members and approving authorities and post-PEB Appellate Review Board members
Frequency	One time per participant	Presented quarterly; participants attend as needed
Length	PEBLOs: Four days PEB members and approving authorities: Four days Appellate Review Board members: Four days Physicians: Four hours Commanders: One hour PEB Administrative Action Officers: Two days Patient Administrators: One day	Four days
Location	Trainee's duty station	OSD or a military department's facilities in the Washington, D.C., metropolitan area

[a]The development time estimated here is based in the fact that the military departments have subject matter experts with experience in developing training curricula and that basic modules will be used in each of the population-specific training packages. If development time exceeds our estimate, training costs will increase.

Table 7.3

Cost of Self-Directed Computer-Based Distance Training

Year	Subject Matter Experts	Outside Developer	Department of the Army	Department of the Navy	Department of the Air Force	Total Cost	NPV Cost
0	$130,349	$500,000	—	—	—	$578,210	$630,349
1	$ 6,517	$5,000	$1,003,760	$1,141,070	$425,138	$2,581,486	$2,412,604
2	$ 6,517	$5,000	$880,935	$1,019,006	$356,252	$2,267,709	$1,980,705
3	$ 6,517	$5,000	$880,935	$1,019,006	$356,252	$2,267,709	$1,851,126
4	$ 6,517	$5,000	$880,935	$1,019,006	$356,252	$2,267,709	$1,730,025
5	$ 6,517	$5,000	$880,935	$1,019,006	$356,252	$2,267,709	$1,616,845
Total	$162,937	$525,000	$4,527,499	$5,217,092	$1,850,145	$12,230,533	$10,551,673

We estimate that outside development costs are $500,000 in Year 0. This cost is based on the assumption that (1) the outside developer will provide a professional training developer to work with the subject matter experts to develop the training; (2) a core training module will be used in all of the training packages; and (3) five population-specific training packages will be developed.

The format of self-directed computer-based distance training can cover a wide range of options and prices, from video- and audio-intensive sessions (which can be expensive) to purely text-based sessions (which are typically less expensive). The costs shown in Table 7.4 are based on a primarily text format, as it is unknown whether all of the primary participants will have computers with the capacity to handle the video and audio formats. We estimate that it will cost $5,000 to update the self-directed computer-based distance-training packages. Ideally, these updates will be informed by data gathered by the management information system that we recommend in Chapter 6.

Cost of Classroom Training

We estimate that five years of classroom training will cost $2.23 million. As shown in Table 7.4, the vast majority of the cost of classroom training comes from participant time and travel. The participant time represents the opportunity cost[5] of the participants attending training, a cost[6] to the military departments. When calculating this cost, we included one day of travel time as well as the four days of training.

We assume that the OSD will budget for all other costs—instructors, travel, and materials. The travel cost includes plane fare,[7] hotel, and per diem costs for all participants and instructors.[8] We estimate the material costs of classroom training at $50 per participant per training session. As noted in Table 7.2, this analysis assumes that the training occurs at a military facility that would otherwise have been unused. If this assumption is invalid and the training sessions take place at an outside facility or the facility would have been in use otherwise, an additional cost will accrue.

BENEFITS

The premise underlying this chapter is that training does produce the hypothesized benefits. We must emphasize, though, that training will produce payoffs *only* if training content and delivery focus on precise DES topics that constitute the bodies of knowledge and specific skills required to produce desired on-the-job results. In other words, poorly developed training is unlikely to produce the desired benefits.

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[5]*Opportunity cost* represents what is foregone by undertaking a given action. If the participants were not engaged in OSD-provided training, they would be engaged in other work activities. We estimate the opportunity cost of participation in training throughout the analysis as the participant's pay for the designated unit of time.

[6]We assumed that the training population would primarily consist of PEB members and approving authorities and post-PEB Appellate Review Board members. As a result, this opportunity cost is based upon an O-6's average salary. We expect that others, including Medical Evaluation Board members and approving authorities and attorneys, may also attend this training. Because the average rank of these members is typically lower than O-6, our estimate may overestimate the actual opportunity cost.

[7]We estimate plane fare to cost $300 per person.

[8]We expect that this figure may overestimate the travel cost because some participants or instructors may be stationed in the area where the training occurs.

Table 7.4

Cost of Classroom Training

Year	Instructor	Participant Time	Travel	Subject Matter Experts	Materials	Total Cost	NPV Cost
0	—	—	—	$26,070	—	$26,070	$26,070
1	$17,580	$293,000	$210,304	$6,517	$10,000	$537,401	$502,244
2	$17,580	$293,000	$210,304	$6,517	$10,000	$537,401	$469,387
3	$17,580	$293,000	$210,304	$6,517	$10,000	$537,401	$438,680
4	$17,580	$293,000	$210,304	$6,517	$10,000	$537,401	$409,981
5	$17,580	$293,000	$210,304	$6,517	$10,000	$537,401	$383,160
Total	$87,900	$1,465,000	$1,051,520	$58,657	$50,000	$2,713,077	$2,229,522

We identified both quantifiable and nonquantifiable benefits that will emerge from establishing the recommended training. Although quantifiable benefits appear to be more tangible, we urge OSD and military department leaders not to discount benefits that cannot be quantified. Such benefits can be just as or even more important than benefits that can be quantified and have actual dollar value. A discussion of these benefit types follows.

Quantifiable Benefits

Although training is commonly considered to increase efficiency, customer satisfaction, employee job satisfaction, and morale, few organizations have attempted to measure the benefits of training. Studies that have quantified the benefits of training report a wide range of returns. For instance, one study concluded, based on a subjective measure, that employer-provided training raises productivity by almost 16 percent[9] while also citing results from a Bell Helicopter massive training program that resulted in a productivity increase of 181 percent (Laabs, 1997, p. 9).

Because of such uncertainty in the quantifiable results of training, we make what we consider to be conservative estimates regarding the process improvements resulting from training. Our estimates are just that—estimates. Only empirical testing, ex post, can prove these estimates to be sound. In this section of the chapter, we discuss the benefits of the combined training initiatives, rather than evaluating them separately, although we believe that the classroom training is likely to bring about the vast majority of the nonquantifiable benefits we discuss later in this chapter.

For the DES, the quantifiable benefit that we predict training will produce is a reduction in medical board or case processing time. Ideally, processing time reduction estimates would relate specifically to detailed hypotheses regarding how training will decrease processing time. For example, we hypothesize the following:

- Training PEBLOs will reduce the number medical boards the PEB sends back to the medical evaluation phase at the MTF due to the medical board being administratively incomplete.

[9]As noted in Black and Lynch, (1996), p. 263.

- Training physicians will reduce the number of medical boards the PEB sends back to the MTF because the narrative summary is medically insufficient and/or will reduce the number of instances PEB members must phone MTF physicians for more detailed information about a medical board.
- Training commanders will reduce the number of medical boards the PEB sends back to the MTF for additional nonmedical assessment information and reduce the number of days it takes a commander to submit the nonmedical assessment commander's letter.

In the absence of the baseline data for these detailed steps in the DES,[10] we estimate changes in medical board processing time at the aggregate levels of the Medical Evaluation Board in the medical evaluation phase and the PEB in the physical disability evaluation phase. We assume that the initial year (Year 0) will be spent developing training programs and that training will not be fielded until Year 1. As shown in Table 7.5, we estimate that average Medical Evaluation Board processing time[11] will improve from its current baseline 1.75-percent change in the first year self-directed computer-based distance training is introduced to a 2.5-percent change in the second year. We then assume that the improvements will remain at a constant 2.5-percent rate in the following years; in other words, no further improvements will occur. Again, this improvement figure is in comparison with the current baseline.

We estimate that Physical Evaluation Board processing time[12] will improve at a lesser rate—a 0.75-percent change in the first year and a 1.25-percent change in the following years. We estimate lesser changes in medical board processing time during the first year that training is fielded because we suspect that training may be phased in gradually rather than at day one during the first year training is fielded. If all participants are trained immediately, our estimates for the first year of training may understate the change in medical board processing time and subsequent benefits. We assume a constant reduction in processing time in the subsequent years because it provides a more conservative estimate of the benefits.

Table 7.5

Change in Average Medical Board Processing Time Due to Training Intervention

Year	Phase of Process	Percent Change	Change in Average Processing Time (in Days)		
			Department of the Army	Department of the Navy	Department of the Air Force
Year 0	All	0	0	0	0
Year 1	Medical Evaluation Board	1.75	0.8750	1.155	0.610
	Physical Evaluation Board	0.75	0.2175	0.660	0.138
Additional Years	Medical Evaluation Board	2.50	1.2500	1.650	0.875
	Physical Evaluation Board	1.25	0.3625	1.100	0.230

[10] Not all of the military departments were able to provide us with such detailed process information.

[11] Medical Evaluation Board processing time extends from the date the narrative summary is dictated to the date the medical board is received by the Informal PEB.

[12] PEB processing time extends from the date the Informal PEB receives the medical board to the date of the final reviewing authority's disposition decision.

We predict greater change in medical board processing time during the medical evaluation phase, in part because so many factors and participants influence processing time in that phase. For instance, the medical evaluation phase processing time reflects the amount of time it takes for (1) a PEBLO or patient administrator to assemble all of the required documents, including specialty consults, LOD determinations, nonmedical assessments, and other documents, to complete a medical board; (2) a PEBLO to counsel a service member; (3) a commander to send a nonmedical assessment commander's letter; and (4) a Medical Evaluation Board to process a medical board.

Although we assume the same rate of change for all of the military departments, the effect of this change produces different reductions in the daily measure of average medical board processing time due to differing processing time baselines that exist among the military departments (see Table 7.6).

Based on these estimates, the benefits due to reduced medical board processing time will save the military departments approximately $15.17 million over the five-year period (see Table 7.7). Appendix I contains cost-benefit analysis data detailing the quantifiable benefits for each of the military departments.

Every day that is cut off from the processing time of an active duty medical board results in a quantifiable benefit to the military departments as the time to replace a member (either through separation, retirement, or a return to duty) who is not performing his or her duty is reduced. The faster the DES can move a service member through the system, the less money or time the military departments pay for an unmanned billet. We monetize this benefit by calculating the average daily pay for the

Table 7.6

Average Processing Time, FY1999

	Average Processing Time (in Days)		
Phase of Process	Department of the Army	Department of the Navy	Department of the Air Force
Medical Evaluation Board	50	66	35
PEB	29	88	18

Table 7.7

Quantifiable Benefits for All Military Departments

	Medical Evaluation Board			Physical Evaluation Board				
Year	TDRL Fit	TDRL Separate	Active	TDRL Fit	TDRL Separate	Active	Total Year	NPV Benefit
0	—	—	—	—	—	—	—	—
1	$17,940	$ 41,089	$1,755,679	$5,434	$17,787	$ 747,775	$2,580,316	$2,494,485
2	$17,940	$58,727	$2,509,090	$9,057	$29,646	$1,246,291	$3,870,750	$3,497,192
3	$17,940	$58,727	$2,509,090	$9,057	$29,646	$1,246,291	$3,870,750	$3,268,404
4	$17,940	$58,727	$2,509,090	$9,057	$29,646	$1,246,291	$3,870,750	$3,054,583
5	$17,940	$58,727	$2,509,090	$9,057	$29,646	$1,246,291	$3,870,750	$2,854,750
Total	$84,312	$275,995	$11,792,037	$41,661	$136,370	$5,732,940	$18,063,316	$15,169,414

average member in the system[13] and multiplying that average daily pay by the average reduction in processing time and the number of cases completed by the system each year.

As shown in Table 7.7, we monetized this benefit differently for members who are on the temporary disability retired list (TDRL).[14] For members on active duty, a one-day reduction in processing time equates to a one-day reduction of pay, but for individuals being processed through the DES who are on the TDRL, the cost savings from taking the individual off the TDRL a day earlier depends upon the final adjudication of the case.

Individuals who are continued on the TDRL or who are permanently retired (assuming no change in the final disability rating) receive the same payment after processing as they do during processing.[15] As a result, a reduction in processing time does not affect retired pay disbursements. TDRL cases that result in a fitness determination reduce disbursements by the daily TDRL payment (50 percent of base pay)[16] for each day processing time is reduced. Individuals who are found unfit and separated with severance pay reduce disbursements by the daily TDRL payments minus the cost of paying the individuals severance pay one day earlier. Due to the marginal rate of time preference,[17] a dollar today is worth more than a dollar tomorrow. Based on the 7-percent discount rate used in this analysis, the cost of paying an individual an average severance payment ($30,000) one day early equates to $5.35.

We assumed that 10 percent of the TDRL cases would be found fit, 40 percent would be separated with severance pay, and 50 percent would be permanently retired or retained on the TDRL (with no change in the disability rating).

As is evident in Table 7.7, we do not forecast future caseloads or manning levels, rather we base our calculations on constant caseload and manning levels, which are based on the most recent caseload data provided to us by the military departments

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[13]We assume that the average rank of the members being processed through the DES is E-5. Based on caseload by rank data we received from the Department of the Army, we believe this is a sound and conservative estimate.

[14]We would have liked to include cost information for reservists as well, but not all of the military departments were able to provide us this data.

[15]TDRL payments are made from the Department of Defense Retirement Fund and, therefore, do not directly affect the defense budget. Although the department contributes an amount each month to the fund to pay for future benefits earned in that month, the changes that we recommend in this report are unlikely to affect the calculation of that accrual charge. However, the changes will have an effect on disbursements from the fund and, therefore, from the federal government (even though the department will not see the impact in its budget). We capture that larger impact in our analysis.

[16]Members receive temporary disability retired pay equal to base pay multiplied by the rated percent of disability (or retired pay equal to base pay multiplied by 2.5 percent for each year of service, whichever is greater), but the retired pay cannot fall below 50 percent of base pay or be more than 75 percent of base pay. Our TDRL calculations are conservative, based upon the minimum payment a member will receive while on the TDRL.

[17]The "marginal rate of time preference" is an economic concept. A dollar today is worth more than a dollar tomorrow for everyone. For example, most people would be unwilling to lend someone $100 today in return for $100 next year. People generally value $100 today more than the promise of $100 next year, even if they are certain that it will be repaid and there will be no inflation, because of their preference to consume sooner rather than later. The marginal rate of time preference is the rate at which individuals make marginal trade-offs in consuming now versus later.

(see Table 7.8). If primary participant numbers increase and decrease proportionally with an increase or decrease in caseload, the ratio of costs to benefits will remain the same. If primary participant numbers do not change proportionally to the change in caseload, the ratio of costs and benefits we estimate will not hold. For instance, if the Department of the Navy caseload increases by 2,000 cases per year and no primary participants are added to respond to the increase in caseload, it is likely that processing time would not decrease at the rate we estimate.

We believe the DoD-wide training program recommended in this report will displace much of the current training provided by the military departments. However, we foresee that the military departments will establish a new kind of disability evaluation training that focuses on executing unique departmental human resource and administrative policies and procedures as well as developing other abilities, characteristics, and behaviors required to produce desired results on the job (for instance, developing counseling techniques). As a result, we did not compute any savings from the military departments reducing their current training levels, which may result in a conservative estimate of benefits.

Nonquantifiable Benefits

In addition to savings from reductions in medical board processing time, training produces a number of nonquantifiable benefits for the military departments and the OSD (see Table 7.9). Two such benefits are the increase in consistent application of disability policy *within* the military departments and the increase in consistent application of disability policy *among* the military departments. Although both benefits are important to the OSD, the military departments only benefit from consistent application of policy within the individual military department. Both the self-directed computer-based distance training and classroom training result in more-consistent application of disability policy, but the classroom training produces the greatest gains in the consistent application of policy.

In Chapter 5, we noted that PEB members, PEB approving authorities, and post-PEB appellate review board members, in particular, stand to benefit from collaboration with peers on *how* to uniformly apply the rules, procedures, and other considerations in determining fitness ratings, VASRD codes including analogous codes, and disability ratings. Likewise, Medical Evaluation Board members and approving authorities stand to benefit from collaboration with peers on how to apply disciplined medical retention standards uniformly within military departments as well as the

Table 7.8

Number of Cases (Medical Boards) per Year

Case Type	Department of the Army (FY99)	Department of the Navy (FY98)	Department of the Air Force (FY98)
Active	7,564	9,125	2,954
TDRL	1,472	2,140	833

Table 7.9

Nonquantifiable Benefits from Training

Benefits	Computer-Based Distance Training		Classroom Training	
	OSD	Military Departments	OSD	Military Departments
Consistent application of disability policy within the military departments	X	X	XX	XX
Consistent application of disability policy among the military departments	X		XX	
Increased unit readiness	X	X	X	X
Increased customer satisfaction	X	X	X	X
Increased job satisfaction	X	X	X	X

NOTE: X = nonquantifiable benefits; XX = even-greater nonquantifiable benefits, compared with the alternative training delivery method.

kind and level of medical details required in medical boards for PEB members to adjudicate cases. Through this collaboration, we expect that disability policy will be more uniformly applied both within and among the military departments.

A nonquantifiable benefit accrues to the OSD and the military departments due to increased unit readiness. Although we already captured part of this benefit in the quantifiable benefits, we believe there is an additional nonquantifiable benefit of increased unit readiness that exceeds the military department's cost for a service member. In other words, the sum of the whole (a complete and ready unit) is greater than the sum of its parts (all the individual members of the unit).

Training also increases customer satisfaction. In Chapter 6, we identify the service members being processed through the DES and the military services as customers. We hypothesize that training increases service member satisfaction by reducing case variability and strengthening confidence in the system, and it increases military service satisfaction by lowering the total cost of the system and reducing the time to replace "broken" members.

Furthermore, training results in increased job satisfaction among all the primary participant populations trained. Developing greater knowledge and common understanding of the system plus reducing the number of reworks better enables primary participants to produce desired on-the-job results, which leads to pride in performance and increased job satisfaction.

TRAINING RESULTS

Over the five-year time frame of the intervention, the quantitative benefits outweigh the costs by approximately $2.39 million. As shown in Table 7.10, during the development year, costs outweigh benefits, assuming Year 0 will be dedicated to developing the training packages. During Year 1 of the training, costs again outweigh the benefits. However, the benefits outweigh the costs in each of the remaining years (as reduced costs reflect the impact of shorter processing times).

In addition to the $2.39 million in benefits that training produces, training also produces the nonquantifiable benefits of consistent policy application, increased job and customer satisfaction, and increased unit readiness.

If this analysis understated the change in medical board processing time and the actual changes looked instead like those in Table 7.11,[18] the net present value of the benefits would equate to approximately $27.3 million, causing the total net present value of the training sessions to be approximately $14.5 million.

On the other hand, if one rejects our hypothesis that training results in process improvements (which we believe is a strong hypothesis) and assumes that *no* quantifiable benefits accrue from the training, it would cost approximately $12.78 million over six years (NPV costs from Years 0 through 5) to obtain the nonquantifiable benefits we identified.

Table 7.10

Net Present Value Quantifiable Costs and Benefits

Year	NPV Costs	NPV Benefits	NPV Total
0	$656,419	—	($656,419)
1	$2,997,861	$2,494,485	($503,376)
2	$2,518,245	$3,497,192	$978,947
3	$2,353,500	$3,268,404	$914,904
4	$2,199,532	$3,054,583	$855,050
5	$2,055,638	$2,854,750	$799,113
Total	$12,781,195	$15,169,414	$2,388,219

Table 7.11

Alternate Change in Average Medical Board Processing Time Due to Training Intervention

Year	Phase of Process	Percent Change	Change in Average Processing Time (in Days)		
			Department of the Army	Department of the Navy	Department of the Air Force
Year 0	All	0	0	0	0
Year 1	Medical Evaluation Board	2.50	1.2500	1.65	0.8715
	Physical Evaluation Board	2.25	0.3625	1.10	0.2300
Additional Years	Medical Evaluation Board	5.00	2.5000	3.30	1.7430
	Physical Evaluation Board	2.25	0.6525	1.98	0.4140

[18]We believe the alternate estimate shown in Table 7.11 also has merit.

Chapter Eight

CONCLUSIONS

This concluding chapter frames our recommendations within the context of the central theme of this report. This chapter also offers some observations that suggest further efforts to complement those recommendations.

STUDY OBJECTIVES, APPROACH, AND RECOMMENDATIONS

Improving the performance of the Disability Evaluation System is the central theme of this report. This theme emerges from and encompasses the initial study objective of identifying and recommending changes to the training provided to the primary participants of the DES to ensure consistent application of disability policy, both across and within the military departments.

We addressed the study objective with an issues-based, bottom-up approach. We started by reviewing the OSD and military department policy documents that govern the operation of the DES, attending the various military departments' DES training events, and interviewing numerous and diverse primary participants from all the military departments. Based on these sources of information, we recorded specific differences in terms of how policy was understood, policy application, military department DES operations, availability of system information, and we identified problems.

We restated the differences among the military department DESs and the significant problems that were identified as "issues" affecting the consistent application of disability policy across and sometimes within the military departments. We then formulated desired results—what one would observe if an issue were resolved—for those issues, which led to a set of recommended actions grouped into ten categories of interventions (one of which focuses on training, the study objective) for eliminating the undesirable differences and the problems.

The ASD/FMP, in coordination with the ASD/HA and the ASD/RA, can implement these recommendations (described in Chapter 4) immediately, and doing so will decidedly move the DES toward more-consistent application of disability policy. However, a broader perspective—focused on overall system performance—promises a significantly more far-reaching and profound impact.

In particular, we could have developed the DoD training recommendations based solely on the evidence we uncovered during our search for differences in policy in-

terpretations and applications, operation of the military department DESs, and system information available to inform decisions. In fact, based on subjective performance issues as reported by primary participants, this issues-based, bottom-up approach identified a limited set of DES topics as the basis for a narrowly focused training intervention.

This issues-based, bottom-up training intervention, presented in Chapter 4 among nine other interventions, focuses primarily on improving system efficiency to resolve a common set of continuing problems reported by primary participants across the military departments. As is typical for an issues-based, bottom-up training needs assessment, the resulting narrowly focused training intervention has little or no regard for achieving any specific, uniformly agreed-upon overall system purpose or desired outcomes and improving overall system performance.

Developing and delivering training that is focused on a relatively limited set of DES topics would clearly result in more-consistent application of disability policy. However, such a recommendation would not be well grounded in training theory and application, nor in performance and strategic management theory and application for that matter. In addition, this issues-based, bottom-up approach would not take full advantage of training as a key intervention to improve overall system performance. We decided that a broader, more-robust approach to developing a DoD training intervention was necessary.

Rather than starting with current problems identified by primary participants, a broader approach begins with an analysis of learner needs, referred to as *performance analysis.* Performance analysis determines if a performance problem related to a lack of knowledge or skill exists. The foundation for performance analysis is a published statement of organizational intent—expressed in measurable terms such as goals, objectives, or outcomes—that allows everyone in the organization to focus on and take action to achieve the same stated intent.

In the case of the DoD DES, we propose that the foundation for performance analysis is a published statement of system purpose and desired system outcomes that applies across military departments, as described in Chapter 3. Another critical component of this foundation is a method for monitoring system performance across military departments over time, as described in Chapter 6. Actual recorded performance results point to potential problems or areas that require investigation. Chances are good that some of these problems suggest a lack of knowledge or skill within a primary participant population. This need for additional knowledge or skill development then serves as a basis for developing additional training—which includes preparation of learner-centered objectives, developing content, writing test questions, and such—or modifying existing training and assessing training effectiveness.

The system purpose and desired outcomes, in turn, shape the competencies required for primary participant populations to achieve desired on-the-job results. Stated performance competencies are another prerequisite to developing effective DoD training targeted to the needs of diverse primary participant population clusters across military departments. As noted in Chapter 3, each military department has formulated a unique statement of intent for operating its DES. Aside from OSD policy

language, we found no evidence that statements of desired system outcomes across military departments exist to help focus decisionmaking in regard to consistent application of disability policy or improvement of overall system performance.

Consequently, we employed a purpose-driven, top-down approach to developing the comprehensive training recommendations presented in Chapter 5 that is more-robust than the bottom-up approach. We started with a set of desired system outcomes that explicitly states the intended results of operating the DES to achieve its stated purpose, as proposed in Chapter 3.

Given the existing assignment practices and job designs for primary participant populations, we translated the proposed statements of desired system outcomes into statements that describe the major activities that the primary participant populations must be able to perform to achieve those desired outcomes. These statements shaped the formulation of the proposed competencies that primary participants need in order to achieve both the desired on-the-job results and the overall system outcomes. These competencies then pointed to a DoD training emphasis on applying specific bodies of knowledge and skills across the military departments.

We identified 107 DES topics, including 27 identified using the bottom-up, issues-driven approach described in Chapter 4, as the basis for developing the training packages described in Chapter 5. Based on our assessment of the competencies required for primary participant populations to produce desired on-the-job results to achieve overall desired DES outcomes, we organized the DES topics into specific bodies of knowledge required by the primary participant populations.

We observed that five groups, or clusters, of primary participant populations required essentially the same body of knowledge and skills to produce the desired on-the-job results. We organized those bodies of knowledge into five training packages targeted to the specific performance needs of five primary participant population clusters. These five training packages constitute the course content for a complete DoD disability evaluation training program, which is presented in Chapter 5.

To assess the effectiveness of the training content and its delivery, the OSD needs a comprehensive system for monitoring system performance. Without such a system, the OSD will not be able to evaluate the effectiveness of its training program or the actions to implement other interventions. In addition, although DoD training and a system for monitoring overall system performance are probably the most effective means of improving the performance of the DES, other interventions, such as those described in Chapter 4 that are based on our bottom-up analysis, also contribute to improving system performance.

Consequently, we recommend that the OSD develop a management information system capable of assessing DES performance on a continuing basis in order to identify areas for improvement and develop specific plans for achieving those improvements.

In summary, we recommend the following three major interrelated actions to improve the performance of the DES over time:

1. The ASD/FMP directs the Director of Officer and Enlisted Personnel Management to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which the ASD/FMP, in coordination with the ASD/HA and the ASD/RA, can *decide* upon a system purpose and desired outcomes.
2. The ASD/FMP directs the Director of Officer and Enlisted Personnel Management to

- develop and monitor knowledge-based training in which the content focuses on the suggested list of DES topics that constitute the specific body of knowledge for each of five primary participant population clusters to achieve the desired DES outcomes
- deliver this standardized, knowledge-based training "just-in-time" through self-directed computer-based distance-training packages, each targeting a particular primary participant population cluster, via a DoD Web site devoted to disability evaluation training that is accessible by all primary participants
- supplement this self-directed computer-based distance training with classroom training targeted to two population clusters; this training focuses on *applying* knowledge of a particular set of DES topics to develop the skills necessary to evaluate and adjudicate cases consistently across and within the military departments—a primary determinant of consistent application of disability policy.

3. The ASD/FMP, after consulting on the information needs of the ASD/HA and the ASD/RA, directs the Director of Officer and Enlisted Personnel Management to develop and maintain a comprehensive management information system capable of monitoring relevant performance measures (as they apply to both the active and Reserve components) that enables leaders to assess and analyze DES performance and take action to continually improve that performance.

In Chapter 3, we propose a specific stated purpose for the DES; however, it is only a suggestion based on our analysis. We chose a top-down, purpose-driven approach in order to design and apply a method for developing the proposed training intervention and a set of metrics for use in a management information system intervention. Chapters 5 and 6 describe this method and the metrics. To accomplish the second and third recommended actions, we strongly urge the department to develop its own stated purpose for the DES and desired DES outcomes, and then apply the methodology described in Chapters 5 and 6 using the stated purpose that results from the first recommendation listed in this section.

The direction-setting statements—the purpose and desired outcomes—do not have to be 100-percent perfect; the important thing is to establish them in order to develop and deliver a DoD-wide DES training intervention that begins to positively impact the consistent application of disability policy and overall system performance. Likewise, it is preferable to quickly launch a comprehensive training intervention believed to be an 85- or 90-percent solution and simultaneously commit to making

continuous improvements based on the performance results and lessons learned from the intervention.

Implementing a comprehensive training intervention and the associated management information system intervention will require considerable time and effort before they produce measurable performance results; therefore, they should be initiated immediately.

SYSTEMS PERSPECTIVE OF THE DISABILITY EVALUATION SYSTEM

As stated earlier, consistent with the initial study objective, this report focuses on identifying and resolving problems that contribute to inconsistent application of disability policy within the DES (see Chapter 4). Although achieving a greater degree of consistency in the application of disability policy increases the value of the DES, it is desirable, and possible, to increase its value even more by relentlessly focusing on the *end* of continuously increasing the efficiency of DES operations and overall system performance. The interventions recommended in Chapters 4, 5, and 6 provide the foundation upon which to establish this focus. Developing a systems perspective—routinely monitoring data to provide performance-based feedback that enables decisionmakers to "see" the system interconnections that both *cause* and *effect* performance results—is the *means* to this end. Data are the essential resource for continuously improving efficiency of operations and overall system performance.

Primary participants from all the military departments expressed considerable frustration with the substantial amount of detailed information that they record and report through various systems without knowing how it is used. Each MTF and military department PEB collect data, but to what end?

The military departments report only the medical board processing timeliness measures to the OSD even though they report various other data within their respective departments. In other words, the OSD currently relies solely on medical board processing times to assess the performance of the DES. Furthermore, primary participants perceive that reporting processing timeliness measures to the OSD and meeting (or missing) the OSD-imposed timeliness standard is not really important. They view the standard as merely an arbitrary measure with no real accountability attached to it.

Most primary participants that we interviewed appeared not only interested in improving system operating efficiency but also committed to it. They want to produce results that make them proud of what they do every day. They do not object to collecting data when they understand how the data add value to system operations, but they do object to collecting data just for its own sake.[1]

Some primary participants appear to be in the unenviable position of collecting every possible data element "in case someone asks for it." Yet, when we asked for data

[1]The military departments generate the data collection requirements for essentially all data collected other than data related to timeliness.

on the number of medical boards that are returned to MTFs due to insufficient medical documentation in the narrative summary and the average number of days it takes for a medical board to be returned to an Informal PEB after it is sent back to an MTF for insufficiency, the data were not available from all the military departments.

Likewise, although the military departments provided data we requested on the percentage of service members referred to the PEB who were subsequently found fit and returned to duty and the percentage of Informal PEB decisions service members accepted or appealed, fulfilling the request seemed to take an excessive amount of time, suggesting that the military departments do not routinely query and monitor this data. Similarly, the Office of the ASD/RA cannot monitor aspects of DES performance as it pertains to Reserve component members. Even so, in many instances, significant resources are devoted to data collection.

Deciding on a purpose statement that articulates the fundamental reason the DES exists and a set of desired results from operating the system to achieve that purpose (the desired outcomes) positions the ASD/FMP, the ASD/HA, and the ASD/RA to determine which performance measures—outcome measures, output measures, input measures, or metrics—best assess system performance. This purpose-driven, top-down approach will likely call into question the value of some data currently being collected, while also affirming the value of some data elements that help assess system performance and flagging others that are collected merely out of habit or just in case someone asks for them.

Positioning the Assistant Secretaries to determine which performance measures best assess DES is just one example of how a shared system purpose and set of desired outcomes will add value to the DES. The DES purpose and desired outcomes become the focal point upon which to base complex decisions and take action to continuously improve system performance. The purpose and desired outcomes are the basis for determining exactly what to measure to assess overall system performance in a way that is meaningful and useful to those accountable for DES performance: the ASD/FMP, the ASD/HA, and the ASD/RA; Secretaries of the military departments; the Surgeons General; MTF commanders; and PEB approving authorities.

Monitoring system performance produces data, the essential resource for continuously improving efficiency of operations and overall system performance. It also positions the OSD to champion a systems perspective that focuses on emerging issues or unwarranted variations in policy application and the dynamics within the system that cause them.

Developing a "system-performance perspective"[2] among primary participants and those accountable for the overall performance of the DES enables continuous collaborative investigation of system performance based on feedback from all sources (for example, from primary participant satisfaction surveys, surveys of service mem-

[2]A system-performance perspective is one focused on monitoring and improving system performance.

bers referred to the DES, performance measures—outcome, output, and input, and General Accounting Office [GAO] and Inspector General [IG] reports).

A system-performance perspective enables primary participants and those responsible for overall system performance to "see" the pattern of interrelationships within the system that *causes* and *affects* performance and therefore helps target or focus interventions to improve system performance. The ability to see the interrelationships within the DES reveals a variety of areas or leverage points, some high-leverage and some low-leverage, that may benefit from interventions to improve system performance. A system-performance perspective enables primary participants and those responsible for overall system performance to recognize the impact and tradeoffs of various interventions to improve that performance.

Future investigations based on a system-performance perspective may lead to a host of system interventions focused on identified leverage points, such as developing better measures of overall system performance; revising DES policy; developing new sources of information; changing the process; or implementing training interventions, such as revising the knowledge-based training, introducing new knowledge-based training, or introducing a new method of delivery.

Ideally, a system performance perspective requires a management information system that monitors DES performance at DoD, military department, and MTF levels. The management information system measures actual results compared with desired results and, thereby, focuses training and other interventions on closing the gap between desired outcomes and actual outcomes.

OTHER APPLICATIONS OF THE ISSUES-BASED AND PURPOSE-DRIVEN APPROACHES

Although this report focuses on the DES, the issues-based, bottom-up approach and the purpose-driven, top-down approach applied in this study are applicable to other components of the DES and other systems for which the OSD is responsible.

Applying the two approaches discussed in this report—particularly the purpose-driven, top-down approach presented in Chapter 3—could substantially improve the effectiveness of two key components of the DES that are pertinent to, although not within the scope of, this study: management of the TDRL and application of the DES to the Reserve component.

Many primary participants referred to problems in the management of the TDRL. The military departments vary in their ability to track service members placed on the TDRL, the timeliness of the evaluation of a service member placed on the TDRL, and the attention they give to the TDRL. Although representing only about 5 percent of disability retired pay disbursements, in any given year, approximately 9,000 service members are on the TDRL (out of a total of approximately 120,000 veterans receiving disability retired pay). Approximately 20,000 service members are processed in the DES each year, in addition to approximately 4,500 who are processed from the TDRL.

Whereas primary participants could identify specific problems with the management of the TDRL, many primary participants lacked basic information regarding the application of disability policy to Reserve component service members. This lack of basic information among primary participants makes it impossible to assess the consistency of application of disability policy and overall system performance, but it suggests that neither application of disability policy nor system performance as it applies to the Reserve component is up to the DES level as it applies to the active component.

SUGGESTIONS FOR FUTURE STUDY

If the ASD/FMP, in coordination with the ASD/HA and the ASD/RA, decides on a purpose statement and a set of desired outcomes for the DES, the ASD/FMP could direct the purpose-driven, top-down approach described in Chapter 3 to identify effective interventions in the aforementioned two areas: (1) management of the TDRL, and (2) application of disability policy in the Reserve components. In the absence of an established purpose statement and set of desired outcomes, the Assistant Secretaries could nevertheless direct the issues-driven approach described in Chapter 4 in both these areas.

In any event, we recommend that the ASD/FMP, in coordination with the ASD/HA and the ASD/RA, address TDRL management and application of disability policy in the Reserve components.

The OSD could also apply the two approaches used in this report—issues-driven and purpose-driven—to identify potential problem areas and develop appropriate interventions in other programs in which consistent application of defense-wide policy is an important factor, or to improve program performance. For example, potential candidates that might benefit from the approaches described in this report include TRICARE (the military health-care program) and the Defense Leadership and Management Program (the DoD's training program for senior civilians).

In conclusion, we urge the Assistant Secretary of Defense for Force Management Policy, in coordination with the Assistant Secretary of Defense for Health Affairs and the Assistant Secretary of Defense for Reserve Affairs, to decide on a statement of purpose and a set of desired outcomes for the Disability Evaluation System to serve as the basis for developing and implementing the DoD disability evaluation training program and a supporting management information system. Developing and applying a system-performance perspective to the DES can lead the way to improving overall performance.

Appendix A

OVERVIEW OF THE OFFICE OF THE UNDER SECRETARY OF DEFENSE AND ORGANIZATIONAL RESPONSIBILITY FOR THE DISABILITY EVALUATION SYSTEM

Department of Defense Directive 1332.18 (1996) and Department of Defense Instruction 1332.38 (1996) assign organizational responsibility for the Disability Evaluation System in the Department of Defense to the three Assistant Secretaries of Defense—for Force Management Policy, Health Affairs, and Reserve Affairs—who report to the Under Secretary of Defense for Personnel and Readiness, and to the Secretaries of the military departments.

Before examining the specific responsibilities assigned to these Assistant Secretaries, a brief historical overview of the structure of the Office of the Under Secretary of Defense for Personnel and Readiness is instructive, given that organizational structure naturally influences organizational behavior. This overview establishes the context within which the current organizational elements interact to manage the DES.

An Assistant Secretary of Defense[1] has been assigned to the manpower function since 1950.[2] The position is currently titled the Assistant Secretary of Defense (Force Management Policy).[3] Before the FY 1984 Defense Authorization Act mandated establishment of an additional Assistant Secretary of Defense for Reserve Affairs, the reserve affairs function was sometimes combined with the manpower function, which was also sometimes combined with other functions under the original Assistant Secretary of Defense for Manpower position. Likewise, an Assistant Secretary of Defense has been assigned to the health affairs function since 1953, except from 1961 to 1970, when a presidential appointee with Senate confirmation was not authorized for the function.

These three Assistant Secretaries—for Force Management Policy (formerly known as Manpower), Health Affairs, and Reserve Affairs—operated with relative autonomy until the National Defense Authorization Act of 1994 created the new Under

[1]Assistant Secretary of Defense is a presidential appointee position that requires Senate confirmation.

[2]The DoD was established in 1947, making the Assistant Secretary of Defense one of the longest tenured positions in the DoD.

[3]See Marcum et al. (2001) for a full discussion of the lineage of the Assistant Secretary of Defense for Manpower position.

Secretary of Defense for Personnel and Readiness. Department of Defense Directive 5124.2 (1994) delegated authority to the new Under Secretary of Defense for Personnel and Readiness to exercise authority, direction, and control over the three Assistant Secretaries.

Department of Defense Directive 1332.18 and Department of Defense Instruction 1332.38 assign to the Under Secretary of Defense for Personnel and Readiness, the Assistant Secretaries of Defense, and the Secretaries of the military departments the following responsibilities.

The Under Secretary of Defense (Personnel and Readiness), under DoD Instruction 1332.38

- exercises cognizance and oversight of the DoD DES
- makes the final decision on requests from the military departments for exceptions to the standards in [DoDI 1332.38].

The Assistant Secretary of Defense (Force Management Policy), under DoDD 1332.18

- develops and maintains, in coordination with the Assistant Secretary of Defense for Health Affairs and the Assistant Secretary of Defense for Reserve Affairs, a program of instruction for the DES
- monitors changes and proposed changes to military personnel and compensation statutes and DoD policy, and other pertinent authorities, to assess their impact on physical disability evaluation, Reserve component medical disqualification, and related benefits; and issues timely guidance to the military services, as appropriate
- coordinates with the Assistant Secretary of Defense for Health Affairs and the Assistant Secretary of Defense for Reserve Affairs in developing policy for referral of members into the DES
- issues and maintains DoD Instruction 1332.38.

The Assistant Secretary of Defense (Force Management Policy), under DoD Instruction 1332.38

- exercises cognizance of laws, policies, and regulations that affect the DES
- issues guidance, as required, to further interpret, implement, and govern the policy and procedures for the four elements of the DES
- establishes necessary reporting requirements to monitor and assess the performance of the DES and compliance of the Military Departments with [DoDI 1332.38] and DoDD 1332.18
- coordinates with the Assistant Secretary of Defense for Reserve Affairs concerning the impact of laws and DoD policy on Reserve members who have conditions that are cause for medical disqualification

- coordinates with the Assistant Secretary of Health Affairs in developing procedures for medical issues pertaining to physical disability evaluation
- reviews substantive changes proposed by the military departments to departmental policies and procedures for physical disability evaluation that affect the uniformity of standards for separation or retirement for unfitness because of physical disability or separation of Ready Reserve members for medical disqualification
- develops quality-assurance procedures to ensure that policies are applied in a fair and consistent manner.

The Assistant Secretary of Defense (Health Affairs), under DoD Directive 1332.18

- monitors changes to the statutes, laws, and regulations of the Department of Veterans Affairs to assess their impact on the Department of Defense's application of the Veterans Administration Schedule for Rating Disabilities (VASRD) to service members determined unfit because of physical disability, and issues timely guidance to the Military Services, as appropriate, upon coordination with the Assistant Secretary of Defense for Force Management Policy
- develops and periodically reviews medical standards for referral of service members into the DES
- recommends changes to and maintains DoD Instruction 1332.39
- monitors the medical element of the DES and proposes corrective actions as required
- develops policies for the medical component of the DES, to include the establishment of minimum standards for Medical Evaluation Boards, Reserve component medical examinations forwarded to Physical Evaluation Boards, and TDRL periodic examinations
- develops and maintains a program of instruction for use by MTFs on the preparation of Medical Evaluation Boards for physical disability cases
- develops a program of instruction for use by PEB adjudicators and appellate review authorities on the medical aspects of physical disability adjudication, to include the application of the VASRD
- monitors the timeliness of the medical component of the DES
- develops policy for conduct of maximum interval physical examinations and certification of physical condition for members of the Reserve components.

The Assistant Secretary of Defense (Health Affairs), under DoD Instruction 1332.38

- makes recommendations for a final decision by the Secretary of Defense on the unfit findings on all officers in pay grade O-7 or higher and medical officers in any grade who are pending nondisability retirement for age or length of service at the time of their referral into the DES

- reviews substantive changes proposed by the military departments in their supplemental medical standards to enclosure 4 of [DoDI 1332.38] concerning medical conditions that are cause for referral of a member into the DES.

The Assistant Secretary of Defense (Reserve Affairs), under DoD Directive 1332.18

- ensures the policies for the DES are applicable to members of the Ready Reserve and those policies for the Ready Reserve are consistent with the policies established for active component personnel.

The Assistant Secretary of Defense (Reserve Affairs), under DoD Instruction 1332.38

- Coordinates as necessary to ensure that procedures for the DES apply consistently and uniformly to members of the Reserve components.

The Secretaries of the military departments, under DoD Instruction 1332.18

- ensure compliance with Chapter 61 of 10 U.S.C., [DoD Directive 1332.18], and instructions and guidance issued under [its] authority
- establish the service-specific DES to consist of the four components: medical evaluation; physical disability evaluation, to include appellate review; counseling; and final disposition
- manage the service-specific DES to ensure physical disability evaluation is accomplished in a timely manner with uniform application of the governing laws and DoD policy
- ensure that physicians who serve on Medical Evaluation Boards are trained in the preparation of medical boards for physical disability evaluation
- ensure that PEB members and applicable review authorities are trained and certified in physical disability evaluation
- ensure all matters raising issues of fraud within the DES are investigated and resolved as appropriate
- defer a determination of disability retirement of any officer who is being processed for, is scheduled for, or has received nondisability retirement for age or length of service until such determination is approved by the Under Secretary of Defense for Personnel and Readiness on the recommendation of the Assistant Secretary of Defense for Health Affairs under Section 1216(b) of Title 10, U.S.C.

The Secretaries of the Military Departments, under DoD Instruction 1332.38

- ensure that members with conditions that may be cause for referral into the DES are counseled at appropriate stages on the DES process and the member's rights, entitlements, and benefits
- establish a quality-assurance process to ensure that policies and procedures established by DoDD 1332.18 and [DoDI 1332.38] are interpreted uniformly

- make determinations on unfitness because of medical disqualification or physical disability; entitlement to assignment of percentage of disability at the time of retirement or separation because of physical disability; and except as limited by 10 U.S.C. 1216(d), entitlement to and payment of disability retired and severance pay
- ensure that the record of proceedings for physical disability cases supports the findings and recommendations made
- ensure the Temporary Disability Retired List is managed to meet the requirements of 10 U.S.C. 1210 for timely periodic physical examinations, suspension of retired pay, and removal from the TDRL
- designate a military department representative to serve as the department representative for the Disability Evaluation System
- ensure all matters raising issues of fraud on the DES by members are investigated and resolved as appropriate.

Appendix B

MILITARY DEPARTMENT INTERPRETATIONS OF THE PURPOSE OF THE DISABILITY EVALUATION SYSTEM

No shared philosophy within the OSD or across military departments defines the fundamental reason why the Disability Evaluation System exists—that is, there is no shared statement of its purpose. Lacking direction from the OSD on the purpose of the DES, the military departments fill the void by giving DoD policy language their own interpretation and operate their systems accordingly.

The official documents that govern the military departments' systems express the purpose or objectives of their respective DES differently. Army Regulations govern the operations of the Army DES, Secretary of the Navy Instructions govern the operations of the Department of the Navy DES, and Air Force Instructions govern the operations of the Air Force DES.

DEPARTMENT OF THE ARMY

The Army describes the purpose of its governing regulation (AR 635-40, para. 1-1) as being designed to

- maintain an effective and fit military organization with maximum use of available manpower
- provide benefits for eligible soldiers whose military service is terminated because of a service-connected disability
- provide prompt disability processing while ensuring that the rights and interests of the United States government and the soldier (service member) are protected.

DEPARTMENT OF THE NAVY

The Department of the Navy governing document (Secretary of the Navy Instruction 1850.4D, 1998, para. 3101) focuses on objectives, as follows:

- The maintenance of a physically fit and combat-ready Navy and Marine Corps, including Reserve components
- Equitable consideration of the interests of the government and individual service members.

DEPARTMENT OF THE AIR FORCE

The Air Force governing document (AFI 36-3212, 1998, p. 10) describes the purpose of its Disability Evaluation System as follows:

> To maintain a fit and vital force, disability law allows the Secretary of the Air Force to remove from active duty those members who can no longer perform the duties of their office, grade, rank, or rating and ensure fair compensation to members whose military careers are cut short due to a service-incurred or service-aggravated physical disability.

JOINT SERVICE DISABILITY WORKING GROUP

To address the findings of a DoD Inspector General audit report dated June 1992, the Office of the ASD/HA convened a Joint Service Disability Working Group to analyze the disability evaluation process using the Corporate Information Management methodology. That group articulated the following mission statement for the DOD Disability Evaluation System:

> The military disability evaluation process provides and maintains a fit force, removes unfit members from active duty who can no longer perform duties commensurate with their office, grade, rank, or rating, and provides compensation to members whose military careers are cut short due to a service-incurred or service-aggravated physical disability (Joint Service Disability Working Group, November 17, 1963).

SUMMARY

The four statements of the DES purpose, objectives, or mission in this appendix—all seeking to establish the reason the system exists—offer various renditions and combinations of four themes:

1. All four statements include a "maintain a fit force" theme, as follows:

- Maintain an effective and fit military organization with maximum use of available manpower.
- Maintain a physically fit and combat-ready Navy and Marine Corps.
- Maintain a fit and vital force.
- Provide and maintain a fit force.

2. Three statements include a "provide compensation and benefits" theme:

- Provide benefits for eligible soldiers whose military service is terminated because of a service-connected disability.
- Ensure fair compensation to members whose military careers are cut short due to a service-incurred or service-aggravated physical disability.
- Provide compensation to members whose military careers are cut short due to a service-incurred or service-aggravated physical disability.

3. Two statements include a "remove unfit members from active duty" theme:

- Provide prompt disability processing; remove from active duty those who can no longer perform the duties of their office, grade, rank, or rating.
- Remove unfit members from active duty who can no longer perform duties commensurate with their office, grade, rank, or rating.

4. Two statements include a "balance the interests of the government and the service member" theme:

- Ensure that the rights and interests of the government and the soldier are protected.
- Ensure equitable consideration of the interests of the government and individual service members.

Appendix C

DISABILITY EVALUATION SYSTEM ISSUES

This appendix contains a comprehensive list of issues associated with the Disability Evaluation System. We identified these issues—which address instances of variability in policy application across or within the military departments, as well as some specific problems associated with the DES—during interviews with numerous and diverse primary participants, and in the course of attending the military departments' major training events. These issues serve as the basis for the goal fabric analysis and the resulting actions in the ten categories of interventions discussed in Chapter 4.

1. Medical Evaluation Boards convened too early (for example, shortly before surgery or immediately after post-injury/illness period).
2. The services employ different philosophies for referring service members for Medical Evaluation Boards. For example, the majority of Army service members who receive Medical Evaluation Boards are referred to the PEB and the majority of those are found unfit, whereas the majority of Air Force service members who receive Medical Evaluation Boards have a high probability of returning to duty.
3. DoDD 1332.18 holds the Secretaries of the military departments responsible for ensuring that physicians who serve on Medical Evaluation Boards are trained in the preparation of medical boards for physical disability evaluation. No institutional mechanism exits in any of the military departments to do this. The Departments of the Navy and the Air Force claim to be in the process of updating instructions (published official governing documents) that describe how to conduct Medical Evaluation Boards.
4. In the Department of the Navy, the Medical Evaluation Board fairly frequently (in 5 to 10 percent of the cases) refers medical boards that do not qualify for the DES to the PEB because the referring physicians and commanders do not communicate with each other and the physicians play a strong patient advocate role.
5. No written retention standards exist (except for the Army) and the services use different retention standards. For example, the Army refers service members with asthma to the Medical Evaluation Boards.
6. Confusion exists among members of the Disability Advisory Council and members of the PEBs regarding reasons for nondeployability and use of nondeployability in determinations of fitness.

7. Different military departments' informal PEBs receive different information upon which to make judgments.
8. The military departments allow service members different lengths of time (3, 10, or 15 days) to make an election of informal PEB and formal PEB findings, which impacts service members' perceptions of due process.
9. No reliable information system exists to present performance data to MTF commanders and the Surgeons Generals.
10. Some medical boards are not processed in a timely manner; they linger in the system and are then referred to the PEB after the narrative summary and/or the specialty consults are more than 90 days old.
11. DoD Directive 1332.18 holds Secretaries of the military departments responsible for ensuring that physicians who serve on Medical Evaluation Boards are trained in the preparation of medical boards for physical disability evaluation; however, no institutional mechanism exists in any of the military departments to ensure that this happens. Across the military departments, doctors typically receive no standardized training in writing medical boards (narrative summaries) or specialty consults. Some new doctors may receive a "crash course" on writing narrative summaries, but nothing standardized or consistently used exists within or across the military departments.
12. Many doctors have no understanding of the DES, or they lack knowledge about the information the PEB needs to make appropriate assessments. Many do not fully understand some basic concepts of the DES, such as "service aggravation," "presumption of fitness," or "fit/unfit."
13. An adversarial relationship exists between referring physicians and the Department of the Navy PEB. Doctors spend 16 months (Limited Duty maximum time) treating a service member's medical condition and when they cannot resolve the condition during that time, they refer the service member to the PEB with the expectation that the PEB will find the member "unfit." In cases such as these, some doctors tend to regard a "fit" call by the PEB as a personal affront to their medical expertise. Referring physicians oftentimes do not understand that a PEB determination of "fit for duty" is not equivalent to "fit for full deployment."
14. Nondeployable service members are a particular problem in the Department of the Navy because the Navy does not have many shore billets. Most Department of the Navy assignments require four years of shore duty, then three years of sea duty. Because of this rotation policy, some line officers, physicians, medical policymakers, and assignments personnel in the Department of the Navy would like to see the fit call and suitability standards more closely aligned. Likewise, some operational leaders, physical disability evaluation policymakers, and assignments personnel in the Army also would like to see the deployability and fit calls more closely aligned.
15. The Department of the Navy PEB is finding an increasing number of service members "fit." The fit calls have roughly doubled over the past few years; about

30 percent of the PEB adjudications result in fit calls. Is the increase caused by a change in the PEB philosophy, or a change in the quality of the Medical Evaluation Board or Physical Evaluation Board? The PEBs first got access to the commanders' nonmilitary assessment following publication of the new Secretary of the Navy Instruction 1850.4D in December 1998, and the fit calls subsequently went up (reportedly because the PEBs now had access to the commander's input).

16. DoD Directive 1332.18 and the new SECNAVINST 1850.4D contain examples of a good medical board. Copies reportedly are rarely made available to doctors, and most doctors do not use them even when they are available.

17. Physicians across the military departments who write specialty consults (from orthopedics, pulmonary, cardiac, and other specialty areas) need to be informed about the five specific points they must address when writing their consults in order for the PEBs to adjudicate the cases (for example, sufficiently documenting specific range-of-motion ratings). Cardiac cases most often lack the sufficiently detailed information.

18. Commanders typically do not understand the role or purpose of the DES, or their role within the system. In particular, they do not seem to understand the "tail" (that is, the vast amount of resources) that follows referrals to the Medical Evaluation Board.

19. In the Army, no one physician is responsible for moving a patient's case through the health-care system to a Medical Evaluation Board. As a result, the patient gets passed on for specialty consults and the case can get lost in the process. In the Air Force, the initial contact physician for the specialty ensures that the appropriate consults are done, the narrative summary is dictated, and the medical board is consistent and complete, and the medical board together with the outpatient records is delivered to the Medical Evaluation Board. In the Air Force, the MTF commander ensures that the attending physician notifies the PEBLOs as soon as it appears likely that a service member will require evaluation to determine physical fitness for retention in a duty status (U.S. Department of the Air Force, Physical Disability Division, 1999).

20. Most Department of the Navy service members are referred to Medical Evaluation Boards by the Limited Duty Boards because the service member has spent too much time in a "limited duty" status.[1]

21. PEBs return insufficient or incomplete medical boards to the referring MTF for the following reasons: no, or insufficient, nonmedical assessment or commander's letter; missing LODD; missing appropriate specialty consult(s) or the consults lack sufficient detail to adjudicate a case, for example, no social and

[1]In the Department of the Navy, a service member may receive up to 30 days of "light duty" while undergoing treatment for a medically diagnosed condition. If the member continues to need medical treatment at the end of the 30-day period, he or she may be referred to a Limited Duty Board or a Medical Evaluation Board for further evaluation. The Limited Duty Board may grant the member up to 16 months of Temporary Limited Duty (in up to eight-month increments) and the member may spend up to 30 days in Medical Hold pending completion of a Medical Evaluation Board referral to the PEB.

industrial impairment assessment on psychiatric cases; insufficient signatures (number and specialty of physicians, and the approving authority must be a medical officer); the narrative summary is more than 90 days old and therefore no longer reliable; incomplete narrative summaries that lack the level of detail needed to make a fit/unfit determination and apply the VASRD.

22. PEBLOs with greater tenure, program knowledge, and experience may be (1) more likely to provide service members with accurate expectations of the DES because they can better explain the VASRD rating and disability compensation; (2) more effective in soliciting commanders' letters and LODDs; and (3) more comfortable and effective in using the chain of command to solve problems such as unit commander nonresponsiveness.

23. The members of the Disability Advisory Council and military department's primary participants communicate with one another infrequently.

24. Although DoD Directive 1332.18 identifies medical evaluation as one of four elements of the DES, the medical community does not seem to accept ownership of this element given its apparent reluctance to (1) respond to requests from the PEB to train physicians who write narrative summaries and specialty consults to meet certain standards; (2) incorporate its governing documents into the overall DES documents; (3) strike the appropriate balance in terms of advocacy—physicians seem to emphasize their role of service member advocate over their equally important role of military department advocate.

25. Data with which to make an assessment are not generally provided to senior officials charged with quality assurance.

26. Secretaries of the military departments receive no information regarding how well the DES is working.

27. Human elements—such as emotions, personality issues, good soldier/bad soldier issues, and length of service (when close to 20 years)—hamper efforts to render fair and consistent decisions. PEB decisions change with new members' personal philosophies.

28. The Department of the Navy reserves "Permanent Limited Duty" status for members who have a "significant number of years in service and want to retire," who are very close to retirement when found unfit, or who have special expertise. This tendency seems to be consistent with DoD Directive 1332.18.3.12: "As an exception to general policy, the Secretary concerned, upon the request of the member or upon the exercise of discretion based on the needs of the Service, may continue in a permanent limited duty status either on active duty or in the Ready Reserve, a member determined unfit because of physical disability when the member's Service obligation or special skill and experience justifies such continuation."

29. Primary participants interpret DoD policy and apply it consistently to the best of their ability. However, primary participants do not converse with their counterparts from the other military departments or the OSD, so they have no way of

knowing if they are passing judgments that differ from those of their counterparts in the other military departments.

30. The Departments of the Navy and Army PEBs are physically located in different regions of the country and rarely communicate with one another.

31. DoD Directive 1332.18 holds the Secretaries of the military departments responsible for ensuring PEB members and applicable review authorities are trained and certified in physical disability evaluation. No institutional mechanism exists in any of the military departments to ensure that PEB members and applicable review authorities are "certified" in physical disability evaluation.

32. Physicians often write medical boards for service members from other military departments. The different military departments write medical boards in different ways. Some primary participants think that the ASD/HA should require a standard format for medical boards in all of the military departments.

33. O-6s who serve as PEB president in the Department of the Navy typically stay in the position for only about six months. This turnover, or lack of continuity, precludes those leaders from developing real commitment to the PEB mission and it is nearly impossible for them to champion needed change, such as streamlining operating procedures and revising policy documents, let alone the more difficult challenge of changing the PEB philosophy.

34. Many primary participants suggested that senior OSD leadership appears to take very little interest in the DES and exercises practically no authority in assuring that it operates as it should. They perceive that the only real DES oversight comes from the Director of Officer and Enlisted Personnel Management.

35. No DES process owner exists; none of the primary participants (except the PEBLOs in the Department of the Navy medical centers) in the medical evaluation phase of the DES work for the O-6 who oversees the PEB, who is also the PEB approving authority.

36. Service member patients perceive variability in the application of disability policy because both the DoD and VA rate a physician's diagnosis using the VASRD, but DoD and VA actually evaluate different things for different purposes at different times.

37. Navy PEBLO positions are filled with service members from a variety of career fields with skill sets that are far removed from patient administration and counseling.

38. Military departments describe the purpose of DES differently.

39. Referrals to pre-separation counseling before a PEB decision of unfitness may lead to incorrect and premature expectations of the service member.

40. Military departments conduct Medical Evaluation Boards in different forms (convene or pass medical boards).

41. We observed junior noncommissioned officers and petty officers acting as PEBLOs and Department of the Navy disability evaluation counselors.

42. No institutional mechanism exists for quality assurance.
43. Fitness and rating calls for members with close to but less than 20 years of service are inconsistent because of the desire of some services and some PEBs to retire such individuals.

Appendix D

EXAMPLE OF GOAL FABRIC ANALYSIS DEVELOPMENT

This appendix illustrates the goal fabric analysis framework described in Chapter 4. It presents a single example, starting with three related issues (see Appendix C for the complete list of DES issues), and identifies two desired results associated with the issues, five actions that support the desired results, and one objective that the desired results suggest. This appendix then presents the full set of objectives and the goals they support, based on this issues-based, bottom-up analytic approach. We also illustrate the relationships between issues, desired results, actions, actual results, objectives, and goals.

The illustrative example begins with the following three related issues:

- The military departments adhere to different philosophies when referring service members for Medical Evaluation Boards.
- In the Department of the Navy, the Medical Evaluation Board fairly frequently (in 5 to 10 percent of the cases) refers medical boards that do not qualify for the DES to the Informal PEB because the referring physicians and commanders do not communicate with each other and the physicians play such a strong patient advocate role.
- Service member patients perceive variability in application of disability policy because both the DoD and VA rate the physician's diagnosis using the VASRD, but each department actually evaluates different things for different purposes at different times.

The first two issues listed here suggest the following desired result: Physicians understand the purpose and role of the Medical Evaluation Board in the overall Disability Evaluation System (the purpose and role could differ among the services). The third issue suggests the following desired result: Service members understand the different purposes of DoD and VA disability evaluation. Figure D.1 portrays the relationships between the issues and results.

After examining the complete list of 41 issues (see Appendix C) and their associated desired results using the bottom-up, issues-based goal fabric analytic technique, we conjectured an initial set of objectives that the group of desired results seemed to suggest. For the sake of illustration, the two desired results shown in Figure D.1 seem

to suggest the following objective: Communicate the purpose and role of the Disability Evaluation System.

For both of the desired results shown in Figure D.1, we also specified actions that could bring about those results. For example, to ensure that physicians understand the purpose and role of the Medical Evaluation Board in the overall Disability Evaluation System (the purpose and role could differ among the services), we suggest two actions: In coordination with the ASD/RA and the ASD/HA, the ASD/FMP should direct the Director of Officer and Enlisted Personnel Management to (1) consult with a small group of experienced DES experts representing the military departments' PEBs and the Office of the Surgeons General to produce recommendations upon which the ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on a purpose and role of the Medical Evaluation Board and (2) develop and promulgate the clearly stated purpose and role of the Medical Evaluation Board within the overall DES.

For the second desired result—service members understand the different purposes of DoD and VA disability evaluations—the suggested actions include (1) the OSD develops a brochure and/or Web site for individuals who are separated or retired for disability that focuses on the differences between the DoD and VA systems; services would present the brochure and/or Web site to members during outprocessing at the transition points; (2) the OSD develops a PEBLO and/or service member Web site

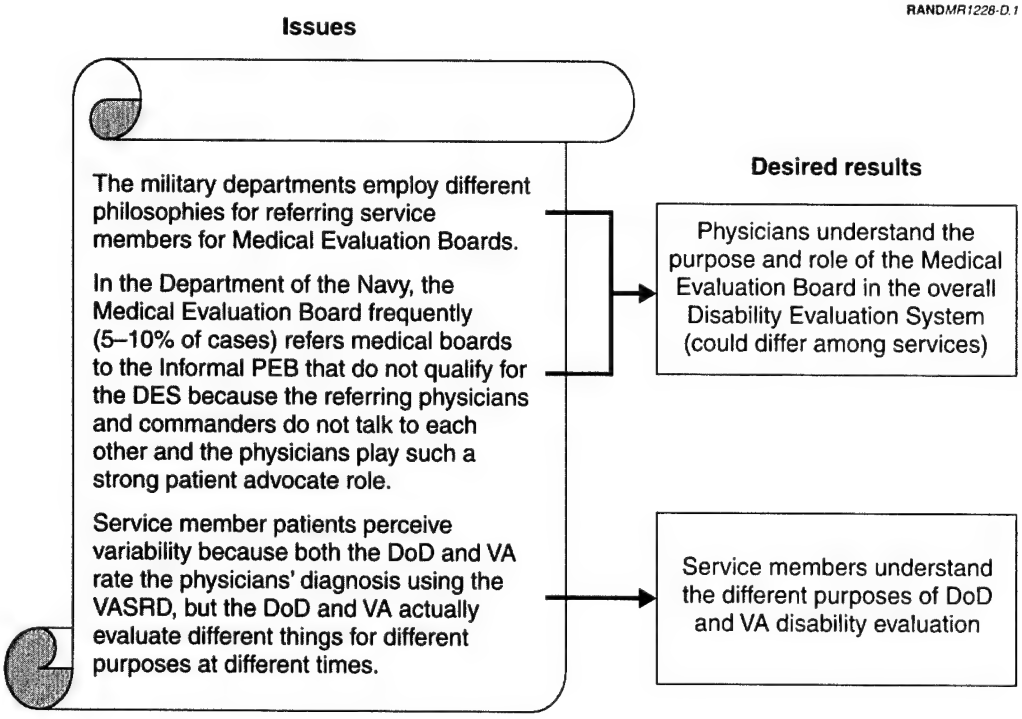

Figure D.1—Issues Leading to Desired Results

and lists the differences between the DoD and the VA disability systems under Frequently Asked Questions; (3) the OSD includes the differences between the DoD and VA systems as a just-in-time training and information topic (on a CD-ROM or Web site); and (4) the OSD makes understanding of DoD and VA systems part of the PEBLO certification process.

All the individual parts—desired results and actions—fit together and become operational when "actual results" are added to the picture (see Figure D.2). Desired results suggest both objectives and actions to achieve them; when the actions are carried out, actual results are obtained. If the actual results when compared with the desired results are consistent with the desired results, those actions clearly contribute to achievement of the stated objective. If they are not consistent with the desired results, the actions (or action) should be modified to produce actual results that are consistent with desired results. Figure D.2 portrays the relationships between actions and results in light of the stated system objective "Communicate purpose and role of Disability Evaluation System."

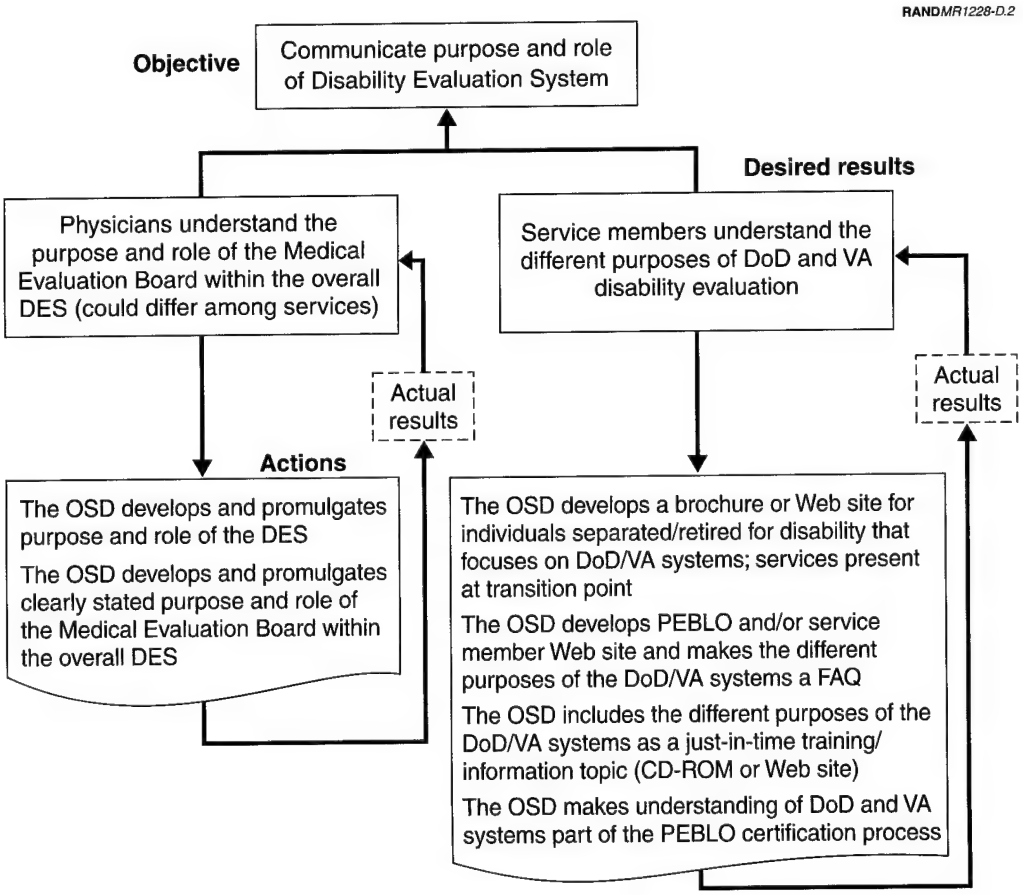

Figure D.2—Relationship Between Actions and Desired and Actual Results

The 41 issues identified during the goal fabric analysis led to a variety of desired results, actions, and objectives. The relationships among them became quite complex. Figure D.2 portrays the kinds of complex relationships that build up to goals. In addition, Figure D.3 illustrates how multiple desired results can serve one objective, and how more than one objective can support a single goal. Each issue suggests one desired result; also, several issues may suggest the same desired result. Each desired result can suggest multiple actions and, although not illustrated here, can serve multiple objectives.

In the example illustrated in Figure D.3, Objectives A and B support the following goal: Develop a shared understanding of the DES and its application within and across the military departments.

As noted earlier, by using this process iteratively, we identified an initial set of objectives and goals. Then, from the perspective of achieving the goals, we examined the set of objectives and the relationships we had posited to the goals to assess their completeness and specificity. Similarly, we examined the desired results supporting the objectives and, lastly, we examined the actions that supported achieving the desired results to assess their completeness and specificity.

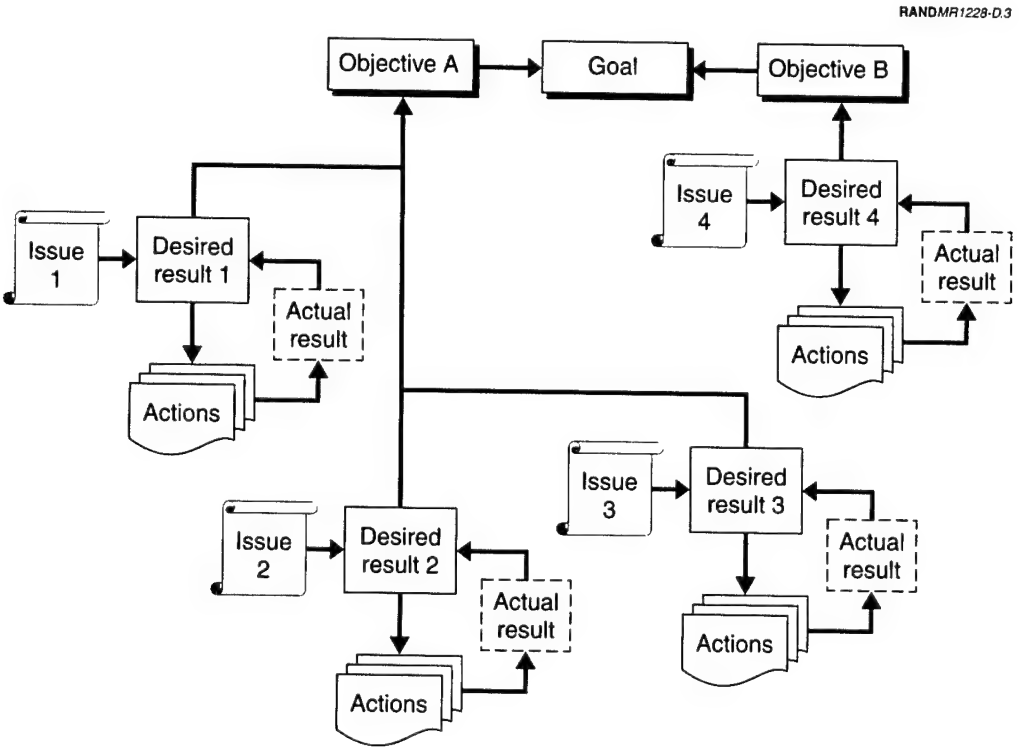

Figure D.3—Multiple Desired Results and Objectives Supporting a Single Goal

When we felt comfortable that the relationships between the issues and the initial sets of desired results, actions, objectives, and goals were logical and complete, we arrived at a final set of objectives. Appendix C lists all of the issues we identified, and Appendix E links the final set of recommended actions (organized into ten categories of interventions) with the eight objectives they are designed to support. The actions provide specificity for achieving the stated objectives. The final set of objectives and goals is shown in Figure D.4.

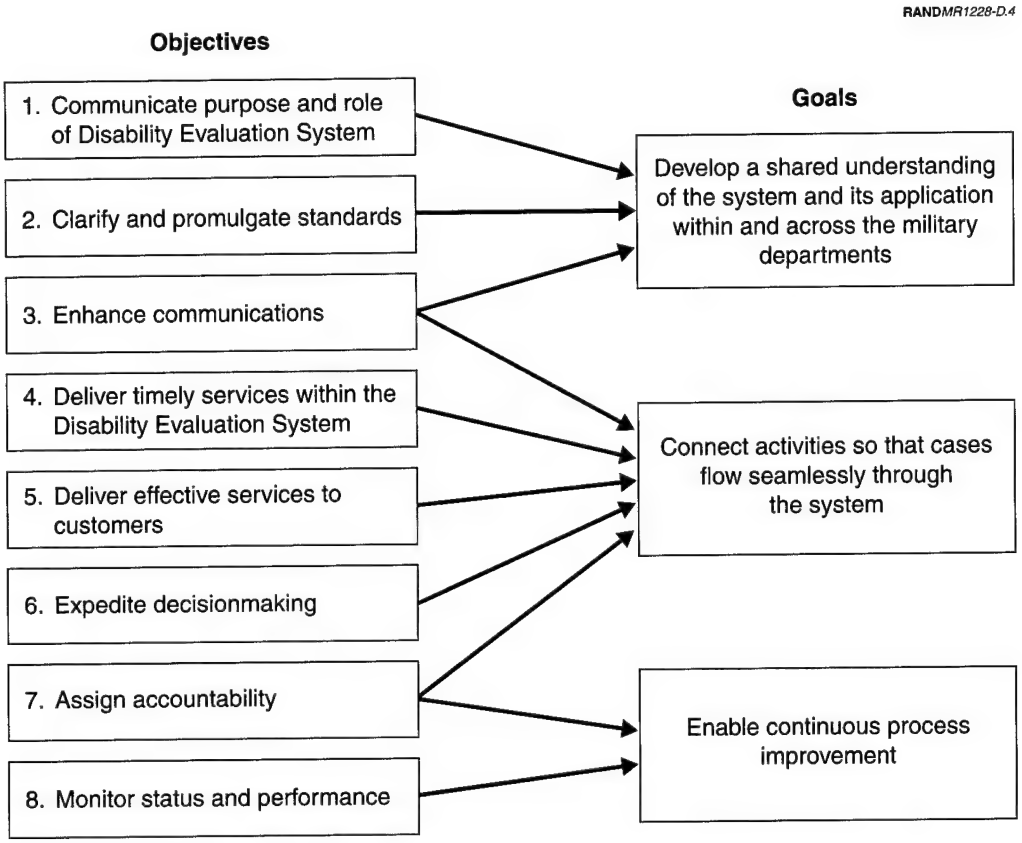

Figure D.4—Multiple Objectives Contributing to Specific Goals

Appendix E

RELATING ACTIONS TO OBJECTIVES

This appendix highlights the link between the interventions for more consistent application of disability policy (and the actions that constitute them) and the objectives those actions are designed to support. The tables in the first half of this appendix group the actions and the DES objective each action supports by intervention category. The tables in the second half of this appendix present the same actions—grouped differently for easy reference—and the intervention category of each by DES objective.

ASSISTANT SECRETARY OF DEFENSE DECISIONS INTERVENTION

As portrayed in Table E.1, the actions composing the Assistant Secretary of Defense Decisions intervention primarily support the objectives of communicating the purpose and role of the Disability Evaluation System and clarifying and promulgating policy application standards. This intervention emphasizes the importance of the OSD leadership setting a clearly articulated direction for the DES to ensure consistent application of disability policy.

POLICY GUIDANCE INTERVENTION

Promulgating policy guidance reifies the agreements reached as part of the Assistant Secretary of Defense Decision intervention. This guidance, together with formal issuance of a clearly articulated direction for conducting business and definition of key concepts, supports the objectives of communicating the purpose and role of the DES and clarifying and promulgating policy application standards. In addition, expansion of certification requirements support the objectives of delivering timely services within the DES, delivering effective services to customers, and monitoring status and performance. Table E.2 presents the policy guidance intervention actions and their related objectives.

ORGANIZATIONAL CHANGE INTERVENTION

Although only two actions fall into the category of organizational interventions, as shown in Table E.3, they are critical to the objectives of expediting decisionmaking and assigning accountability.

Table E.1

Actions and Objectives for the Assistant Secretary of Defense Decision Intervention

Action	DES Objective
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which the ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on a DES purpose and role	Communicate purpose and role of DES
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which the ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on the purpose and role of the Medical Evaluation Board.	Communicate purpose and role of DES
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which the ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on the appropriate time frame for initiating Medical Evaluation Boards	Clarify and promulgate standards
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on standards for referring Medical Boards to the PEB that allow for variations among military departments based on different missions and requirements	Clarify and promulgate standards
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on mechanisms for seamless transmission of medical board information from one military department to another	Clarify and promulgate standards
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on fitness standards and acceptable variation among the services based on different missions and requirements.	Clarify and promulgate standards
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on reasons for nondeployability and use of nondeployability in determinations of fitness.	Clarify and promulgate standards

Table E.1—Continued

Action	DES Objective
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP in coordination with the ASD/HA and ASD/RA can decide on what information to use to determine fitness and disability ratings	Clarify and promulgate standards
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on a consistent period of time among the services to allow for service member election of options following a PEB (or higher level appellate review board) decision or explain the differences that would allow for due process	Clarify and promulgate standards

Table E.2

Actions and Objectives for the Policy Guidance Intervention

Action	DES Objective
OSD—develop and promulgate purpose and role of the DES	Communicate purpose and role of the DES
OSD—develop and promulgate clearly stated purpose and role of the Medical Evaluation Board within the overall DES	Communicate purpose and role of the DES
OSD—develop and promulgate policy defining appropriate time frame for initiating Medical Evaluation Board	Clarify and promulgate standards
OSD—develop and promulgate clearly stated standards for referring medical boards to a PEB	Clarify and promulgate standards
Services—develop and promulgate clearly stated fitness standards	Clarify and promulgate standards
OSD—develop and promulgate clear policy regarding reasons for nondeployability and use of nondeployability in determinations of fitness	Clarify and promulgate standards
OSD—develop and promulgate clear policy regarding what information is used to determine fitness and disability rating	Clarify and promulgate standards
OSD—develop and promulgate clearly stated policy that provides for a consistent period of time for service member election of options across the services or a rationale for differences in policy that would provide due process	Clarify and promulgate standards
The Department of the Navy—assess the criteria for assigning service members to Limited Duty in the context of determining the appropriate time frame for Medical Evaluation Board referral	Clarify and promulgate standards
OSD—develop and promulgate clearly stated standards for the mechanisms for seamless transmission of medical board information from one military department to another	Deliver timely services within the DES
OSD—develop and implement certification procedures	Deliver timely services within the DES

Table E.2—Continued

Action	DES Objective
OSD—test primary participants' understanding of appropriate fields of knowledge; require certification	Deliver timely services within the DES
OSD—develop certification standards	Deliver effective services to customers
OSD—develop certification standards that support desired outcomes	Monitor status and performance

Table E.3

Actions and Objectives for the Organizational Change Intervention

Action	DES Objective
USD/PR—establish procedures and a forum at the level of the Deputy Assistant Secretaries of Defense and their counterparts in the military departments	Expedite decisionmaking
Secretary of each military department—designate an overall process owner for that department's DES	Assign accountability

PERSONNEL POLICY INTERVENTION

Personnel policy actions support the objectives of clarifying and promulgating standards and assigning accountability. The first two actions shown in Table E.4 require a review of policies outside the boundary of the DES, but they are important, nonetheless, because of the incentives they may create within the system to "overadvocate" for the patient. The third and fourth actions in the table tie individual performance to the primary participants' impact on the system.

Table E.4

Actions and Objectives for the Personnel Policy Intervention

Action	DES Objective
The services—assess the difficulty of placing service members who are fit but not deployable into units that can utilize their skills and experience	Clarify and promulgate standards
The OSD—articulate an explicit policy with regard to fitness and disability ratings for a service member who is nearing 20 years of service	Clarify and promulgate standards
OSD—review the impact of the Defense Authorization Act of 1993 amendment to 10 U.S.C. 1142 that requires providing pre-separation counseling for service members not later than 90 days before separation, as it applies to service members undergoing disability evaluation	Clarify and promulgate standards
Designated process owners—assess the performance of the military department PEB approving authority and the MTF commanders and provide the assessment to the officials who write their performance evaluation reports	Assign accountability

PERSONNEL MANAGEMENT INTERVENTION

Table E.5 highlights an instance in which a single action supports several objectives. In this case, the assignment of PEB approving authorities to a position for at least five years supports the objectives of enhancing communications, delivering timely and effective services, and expediting decisionmaking. In addition, assigning PEBLOs for longer tours and monitoring the length of those assignments supports the objective of delivering effective services to customers.

Table E.5

Actions and Objectives for the Personnel Management Intervention

Action	DES Objective
Military departments—assign PEB approving authority for a minimum of five years	Enhance communications Deliver timely services within the DES Deliver effective services to customers Expedite decisionmaking
Military departments—increase capabilities of PEBLOs to generate accurate expectations through combination of experience, training, and information support	Deliver effective services to customers
Military departments—monitor assignments	Deliver effective services to customers

TRAINING INTERVENTION

Although Chapter 5 describes the major recommendations regarding training, two related actions support the objective of enhancing communications and a third action supports two other objectives, as shown in Table E 6.

Table E.6

Actions and Objectives for the Training Intervention

Action	DES Objective
OASD/FMP—develop and deliver training designed to expedite medical board processing	Deliver timely services within the DES Clarify and promulgate standards
Disability Advisory Council—sponsor cross-military department symposia or workshops	Enhance communications
Military departments—conduct annual symposia for all primary participant populations to present, review, and analyze military department DES data and propose corrective actions and identify best practices	Enhance communications

INFORMATION SOURCE DEVELOPMENT INTERVENTION

Table E.7 shows the importance of the actions constituting the information source intervention—they influence the attainment of five objectives. In most cases, these actions support or flow from actions found in other intervention categories.

Table E.7

Actions and Objectives for the Information Source Development Intervention

Action	DES Objective
OSD—develop a brochure and/or Web site for individuals separated or retired for disability that describes the service member's rights, benefits, and entitlements and the significance and consequences of the determinations reached, including a comprehensive comparison of the VA and the DoD disability systems	Communicate purpose and role of Disability Evaluation System
Military departments—publish instruction or regulation that describes format and content of medical boards	Clarify and promulgate standards
OSD—develop database of "best practices" in the DES	Enhance communications
OSD—establish a list server for Medical Evaluation Board approving authorities; PEB members and approving authorities; and for PEBLOs	Enhance communications
MTF commanders—send a sample of a good nonmedical assessment commander's letter with the letter notifying the unit commander that a service member is being referred to the DES	Deliver timely services within the DES
OSD—include in Web site examples of commander's letters; Web-based template with instant transmission to PEBLO	Deliver timely services within the DES
The Office of the Surgeons General—update medical policy documents to match OSD and military department disability policy documents	Deliver timely services within the DES
OSD—develop an information source that primary participants cannot take with them when they rotate to new assignments and that invites interaction via the Internet	Deliver timely services within the DES
OSD—develop user-friendly guide to narrative summary requirements (tests and measures) for the major five specialties; instruct physicians to use it when dictating narrative summaries	Deliver timely services within the DES
OSD—develop user-friendly guide to narrative summary requirements (tests and measures) for all diseases or injuries and instruct physicians to use it when dictating narrative summaries	Deliver timely services within the DES
OSD—develop a tool to measure customer satisfaction (survey)	Deliver effective services to customers
OSD—develop information tools to enhance PEBLO's capabilities: list server, lists of telephone numbers, Web sites	Deliver effective services to customers

MANAGEMENT INFORMATION SYSTEM DEPLOYMENT INTERVENTION

The actions related to the management information system all support the objective of monitoring DES status and performance. The actions derived from the issues regarding a management information system (shown in Table E.8) represent a small portion of the overall recommendations regarding the structure of the system, which emphasize the value of a top-down approach to measuring system performance. (See Chapter 6 for a discussion of the specifications of the management information system.)

Table E.8

Actions and Objectives for the Management Information System Deployment Intervention

Action	Objective
OSD—develop certification standards that support desired outcomes	Monitor DES status and performance
OSD—develop a reporting framework or format for use by the MTF commanders and the Surgeons General	Monitor DES status and performance
OSD—develop, and military departments employ, a monitoring system to track cases from narrative summary dictation to MTF commander signature	Monitor DES status and performance
OSD—employ consistent processing measures; military departments monitor and report processing time for medical boards	Monitor DES status and performance
Military departments—collect data on returned medical boards by reason, by physician, PEBLO, and unit commander; report this data to the MTF commander	Monitor DES status and performance
OSD—develop an institutional mechanism for quality control or assurance	Monitor DES status and performance
DES process owners—report results to Secretaries of the military departments	Monitor DES status and performance
OSD—develop mechanism for providing information on the number of physicians trained to Secretaries of the military departments	Monitor DES status and performance
DES process owners—present certification data to Secretaries of the military departments	Monitor DES status and performance
OSD and the military departments—develop organizational capability to use data to improve system operation	Monitor DES status and performance

PROCESS INTERVENTION

Our analysis of the issues related to the disability evaluation "process" suggested several actions, shown in Table E.9, which complement actions in other intervention categories that support the objectives of delivering timely services within the DES, assigning accountability, and monitoring status and performance.

Table E.9

Actions and Objectives for the Process Intervention

Action	DES Objective
OSD—direct the military departments to implement a procedure whereby a Medical Evaluation Board decision to forward a case to the PEB would trigger a letter from the MTF commander to the unit commander explaining the unit commander's role in the process	Deliver timely services within the DES
MTF commanders—designate and train one physician at each MTF to dictate all narrative summaries; explore other options for focusing expertise in writing narrative summaries	Deliver timely services within the DES

Table E.9—Continued

Action	DES Objective
MTF commanders—designate a case owner (for example, in the Air Force, the referring physician owns the case); PEBLOs could also serve this function	Assign accountability
OSD and military departments—develop organizational capability to use data to improve system operation	Monitor status and performance

INCENTIVES INTERVENTION

We identified only one specific action as an incentive intervention, shown in Table E.10. However, as noted in Chapter 4, expanded recognition and reward programs would substantially support the objective of assigning accountability.

Table E.10

Action and Objective for the Incentives Intervention

Action	DES Objective
PEBs—publicly recognize the best-performing MTFs annually with an award of excellence	Assign accountability

LINKING ACTIONS TO DES OBJECTIVES

Tables E.11 through E.18 present the same actions that appear in the tables in the previous sections. In this group of tables, however, the actions and their associated intervention categories are grouped by DES objective.

Table E.11

Actions and Interventions for the Communicate Purpose and Role of Disability Evaluation System Objective

Action	Category of Intervention
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on a DES purpose and role	Assistant Secretary of Defense Decision
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on the purpose and role of the Medical Evaluation Board	Assistant Secretary of Defense Decision
OSD—develop and promulgate purpose and role of the DES	Policy Guidance
OSD—develop and promulgate clearly stated purpose and role of the Medical Evaluation Board within the overall DES	Policy Guidance

Table E.11—Continued

Action	Category of Intervention
OSD—develop a brochure and/or Web site for individuals separated or retired for disability that describes the service member's rights, benefits, and entitlements and the significance and consequences of the determinations reached, including a comprehensive comparison of VA and DoD disability systems	Information Source

Table E.12

Actions and Interventions for the Clarify and Promulgate Standards Objective

Action	Category of Intervention
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on the appropriate time frame for initiating Medical Evaluation Board	Assistant Secretary of Defense Decision
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on the standards for referring medical boards to the PEB that allow for variations among military departments based on different missions and requirements	Assistant Secretary of Defense Decision
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on fitness standards and acceptable variation among the services based on different missions and requirements	Assistant Secretary of Defense Decision
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on reasons for nondeployability and use of nondeployability in determinations of fitness	Assistant Secretary of Defense Decision
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on what information to use to determine fitness and disability ratings	Assistant Secretary of Defense Decision

Table E.12—Continued

Action	Category of Intervention
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on a consistent period of time among the services to allow for service member election of options following a PEB (or higher level appellate review board) decision or explain the differences that would allow for due process	Assistant Secretary of Defense Decision
OSD—develop and promulgate policy defining appropriate time frame for initiating Medical Evaluation Board	Policy Guidance
OSD—develop and promulgate clearly stated standards for referring medical boards to a PEB	Policy Guidance
Services—develop and promulgate clearly stated fitness standards	Policy Guidance
OSD—develop and promulgate clear policy regarding reasons for nondeployability and use of nondeployability in determinations of fitness	Policy Guidance
OSD—develop and promulgate clear policy regarding what information is used to determine fitness and disability rating	Policy Guidance
OSD—develop and promulgate clearly stated policy that provides for a consistent period of time for service member election of options across the services or a rationale for differences in policy that would provide due process	Policy Guidance
The Department of the Navy—assess the criteria for assigning service members to Limited Duty in the context of determining the appropriate time frame for Medical Evaluation Board referral	Policy Guidance
Services—assess the difficulty of placing service members who are fit but not deployable into units that can utilize their skills and experience	Personnel Policy
OSD—articulate an explicit policy with regard to fitness and disability ratings for service member who is nearing 20 years of service	Personnel Policy
OSD—review the impact of the Defense Authorization Act of 1993 amendment to 10 U.S.C. 1142 that requires providing pre-separation counseling for service members no later than 90 days before separation, as it applies to service members undergoing disability evaluation	Personnel Policy
Military departments—publish instruction or regulation that describes format and content of medical boards	Information Source

Table E.13

Actions and Interventions for the Enhance Communications Objective

Action	Category of Intervention
Military departments—assign PEB approving authorities for a minimum of five years	Personnel Management
OASD/FMP—develop and deliver training designed to expedite medical board processing	Training

Table E.13—Continued

Action	Category of Intervention
Disability Advisory Council—sponsor cross-military department symposia or workshops	Training
Military departments—conduct annual symposia for all of the primary participant populations to present, review, and analyze military department DES data and propose corrective actions and identify best practices	Training
OSD—develop database of "best practices" in the DES	Information Source
OSD—establish a list server for Medical Evaluation Board approving authorities; PEB members and approving authorities; and for PEBLOs	Information Source

Table E.14

Actions and Interventions for the Deliver Timely Services Within the Disability Evaluation System Objective

Action	Category of Intervention
ASD/FMP—direct the Director, Officer and Enlisted Personnel Management, to consult with a small group of experienced DES experts representing the military departments' PEBs and Office of the Surgeons General to produce recommendations upon which ASD/FMP, in coordination with the ASD/HA and ASD/RA, can decide on mechanisms for seamless transmission of medical board information from one military department to another	Assistant Secretary of Defense Decision
OSD—develop and promulgate clearly stated standards for the mechanisms for seamless transmission of medical board information from one military department to another	Policy Guidance
OSD—develop and implement certification procedures	Policy Guidance
OSD—test primary participants' understanding of appropriate fields of knowledge; require certification	Policy Guidance
Military departments—assign PEB approving authorities for a minimum of five years	Personnel Management
OASD/FMP—develop and deliver training designed to expedite medical board processing	Training
Office of the Surgeons General—update medical policy documents to match OSD and military department disability policy documents	Information Source
OSD—develop an information source that primary participants can not take with them when they rotate to new assignments and that invites interaction via the Internet	Information Source
MTF commanders—send a sample of a good nonmilitary assessment commander's letter with the letter notifying the unit commander that a service member is being referred to the DES	Information Source
OSD—include in Web site examples of commander's letter; Web-based template with instant transmission to PEBLO	Information Source

Table E.14—Continued

Action	Category of Intervention
OSD—develop user-friendly guide to narrative summary requirements (tests and measures) for the major five specialties; instruct physicians to use it when dictating narrative summaries	Information Source
OSD—develop user-friendly guide to narrative summary requirements (tests and measures) for all diseases or injuries and instruct physicians to use it when dictating narrative summaries	Information Source
MTF commanders—designate and train one physician at each MTF to dictate all narrative summaries; explore other options for focusing expertise in writing narrative summaries	Process
OSD—direct the military departments to implement a procedure whereby a Medical Evaluation Board decision to forward a case to the PEB would trigger a letter from the MTF commander to the unit commander stating the intent to process the member through the DES, detailing the process, and explaining the unit commander's role in the process	Process

Table E.15

Actions and Interventions for the Deliver Effective Services to Customers Objective

Action	Category of Intervention
OSD—develop certification procedures	Policy Guidance
Military departments—increase capabilities of PEBLOs to generate accurate expectations through combination of experience, training, and information support	Personnel Management
Military departments—assign PEB approving authorities for a minimum of five years	Personnel Management
Military departments—monitor assignments	Personnel Management
OSD—develop information tools to enhance PEBLO's performance capabilities: list server, lists of telephone numbers, Web site	Information Source
OSD—develop a tool to measure customer satisfaction (survey)	Information Source

Table E.16

Actions and Interventions for the Expedite Decisionmaking Objective

Action	Category of Intervention
USD/PR—establish procedures and a forum at the level of the Deputy Assistant Secretaries of Defense and their counterparts in the military departments	Organizational Change
Military departments—assign PEB approving authorities for a minimum of five years	Personnel Management

Table E.17

Actions and Interventions for the Assign Accountability Objective

Action	Category of Intervention
Secretary of each military department—designate an overall process owner for that department's DES	Organizational Change
Designated process owners—assess the performance of the military department PEB approving authority and MTF commanders and provide the assessment to the officials who write their performance evaluation reports	Personnel Policy
MTF commanders—designate a case owner (for example, in the Air Force the referring physician owns the case); PEBLOs could also serve this function.	Process
PEBs—publicly recognize the best-performing MTFs annually with an award of excellence	Incentive

Table E.18

Actions and Interventions for the Monitor Disability Evaluation System Status and Performance Objective

Action	Category of Intervention
OSD—develop certification standards that support desired outcomes	Policy Guidance
OSD—develop a reporting framework or format for use by the MTF commanders and the Surgeons General	Management Information System Deployment
OSD—develop and employ a monitoring system to track cases from narrative summary dictation to MTF commander signature	Management Information System Deployment
OSD—employ consistent processing measures; military departments, monitor and report processing time for medical boards	Management Information System Deployment
Military departments—collect data on returned medical boards by reason, physician, PEBLO, and unit commander; report this data to the MTF commander	Management Information System Deployment
OSD—develop an institutional mechanism for quality control or assurance	Management Information System Deployment
DES process owners—report results to Secretaries of the military departments	Management Information System Deployment
OSD—develop mechanism for providing information on the number of physicians trained to Secretaries of the military departments	Management Information System Deployment
DES process owners—present certification data to Secretaries of the military departments	Management Information System Deployment
OSD and the military departments—develop organizational capability to use data to improve system operation	Process

Appendix F

COMPARING THE ISSUES-DRIVEN AND PURPOSE-DRIVEN ANALYTIC APPROACHES

In this appendix, we compare the two fundamental approaches that we used to study the Disability Evaluation System—the purpose-driven, top-down approach, as described in Chapters 3, 5, and 6, and the issues-driven, bottom-up approach, as described in Chapter 4. We regard any system as a set of interrelated actions connected in a specific order, which presents a logical plan for linking various actions in order to accomplish certain desired outcomes.

Both of the approaches we used in this study impart order to the numerous actions that collectively make up the DES. Each approach relies on different but related constructs to present the proposed actions, which are bundled within categories of interventions, and an overall plan for achieving the desired outcomes. However, issues form the empirical basis for action in the bottom-up approach, whereas actual outcomes measured against desired outcomes and the stated system purpose form the basis for action in the top-down approach. This appendix describes the relationships among the various constructs within the context of these two approaches.

PURPOSE-DRIVEN APPROACH

Ideally, we would have preferred to employ a single top-down approach, such as illustrated in Figure F.1. Such an approach, however, would require a commonly agreed upon purpose for the DES, a set of desired system outcomes, and an information system to measure actual outcomes against desired outcomes. In that context, the observed differences between desired and actual outcomes would lead to the identification and recommendation of interventions to eliminate those differences. As a key intervention, effective training, in particular, must be based on both specific and measurable training objectives tied to the desired system outcomes and on an assessment of how well the objectives are currently being achieved.

In the top-down approach, when the desired outcomes are achieved, the system accomplishes its purpose. The desired outcomes suggest the kind of data the management information system must gather and also the competencies the primary participants need to perform their jobs effectively. By comparing actual outcomes with desired outcomes, the management information system establishes the basis for training and other interventions.

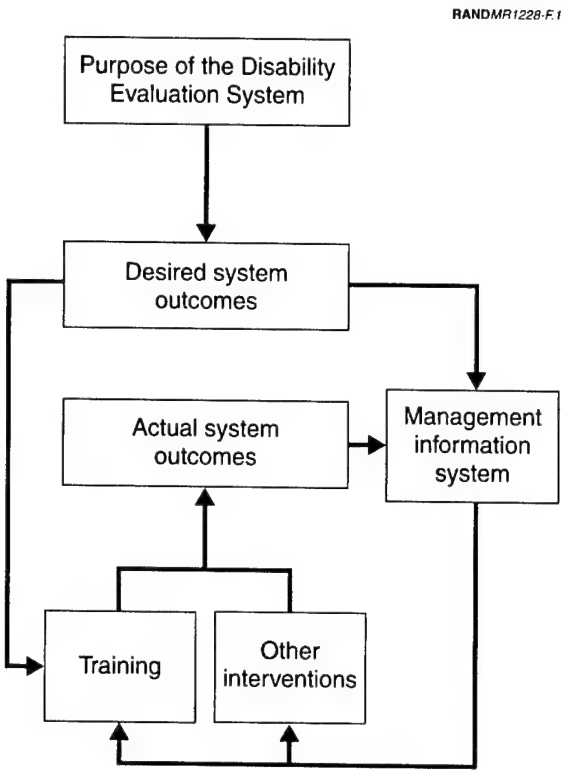

Figure F.1—The Purpose-Driven, Top-Down Approach

Chapter 3 of this report describes a suggested purpose and five supporting outcomes. We use the outcomes in two ways:

- Four of the five outcomes lead directly (and the fifth leads indirectly) to the identification of competencies needed by the primary participants in order for them to accomplish the purpose of the DES. We base the design of training intervention (discussed in Chapter 5) on the bodies of knowledge underlying these competencies.
- All five outcomes lead to the functional specifications for an information system, as discussed in Chapter 6. This system, once deployed, will provide the means to identify problems in the consistent application of disability policy over time and provide a more concrete foundation upon which to shape training in the future.

ISSUES-DRIVEN APPROACH

Based on our conversations with primary participants and information gathered at workshops and training sessions, we identified dozens of specific problem areas, or issues, related to the consistent application of disability policy that exist within the current DES. To develop recommendations for immediate execution, we employed a goal fabric framework—an issues-driven, bottom-up approach as illustrated in Figure F.2—that capitalized on the data we gathered.

This approach helped identify the desired results—what we would observe (related to the issue) if the difference were eliminated or the problem solved—and specific actions that would bring about the desired results. To ensure that the actions are comprehensive, this approach aligns desired results in terms of the objectives they satisfy and aligns objectives in terms of the goals they satisfy. The final product of this analysis, ten categories of interventions (composed of similar actions), represents a comprehensive plan for moving toward consistent application of disability policy.

INTEGRATING THE APPROACHES

The issues-driven and purpose-driven approaches are actually not as different as they might first appear to be. Figure F.3 suggests their relative similarities.

The goals and objectives of the bottom-up approach function in much the same manner as the DES purpose does in the top-down approach, and the desired results in one are similar to the desired outcomes in the other. As stated earlier in this appendix, issues form the empirical basis for action in the bottom-up approach,

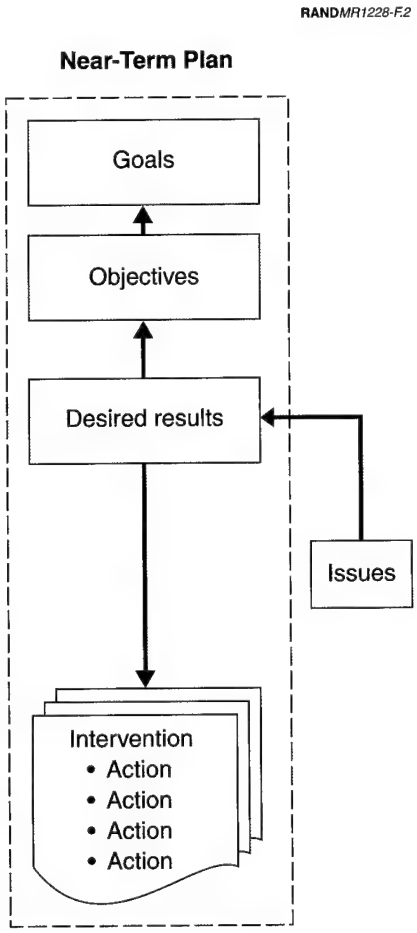

Figure F.2—The Issues-Driven, Bottom-Up Approach

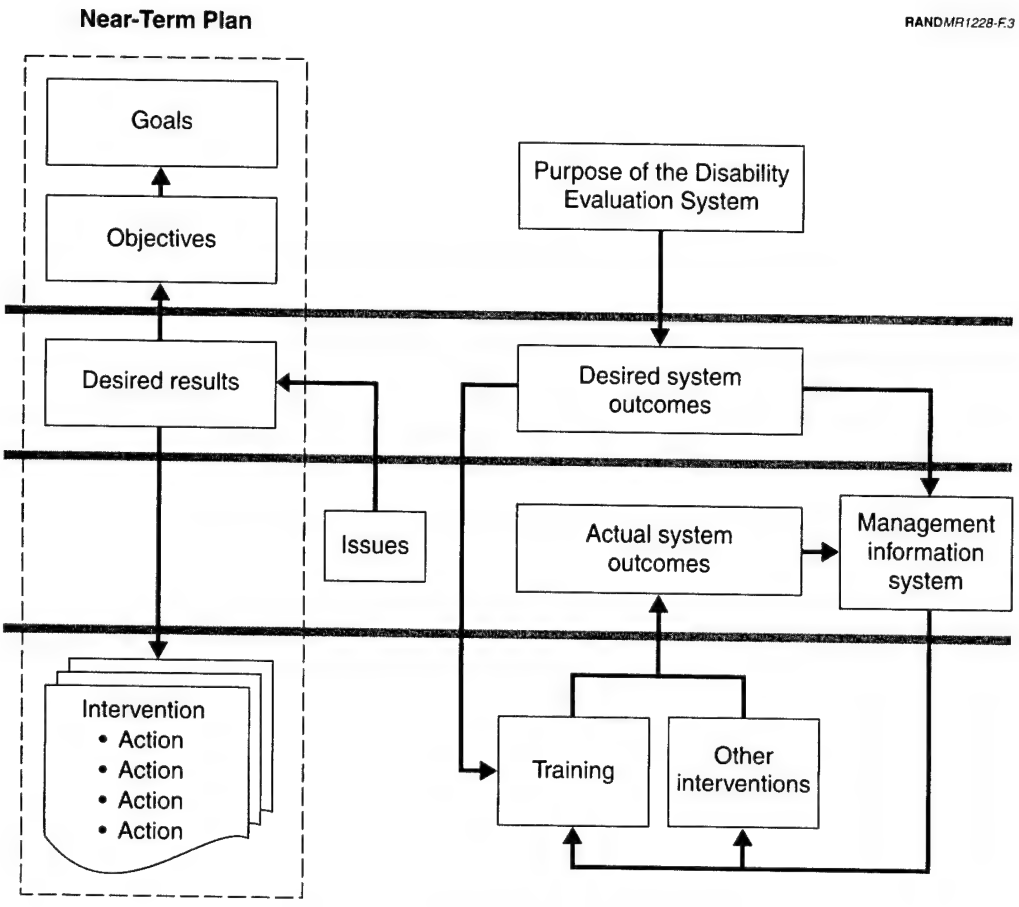

Figure F.3—Comparing the Two Approaches

whereas actual outcomes as measured by the management information system serve that function in the top-down approach. Actions grouped into categories of interventions correspond to the training, management information system, and other interventions in the top-down approach.

We employed each approach to accomplish different tasks. The bottom-up approach was very fruitful in identifying shortfalls in the consistent application of disability policy, which the OSD can rectify immediately by implementing specific interventions. This approach also affirmed the necessity of pursuing standardized training for the primary participants and developing a management information system to monitor the performance of the system.

Although the bottom-up approach is the basis for the recommended interventions presented in Chapter 4, it does not provide enough of a foundation for actually designing the training intervention or developing the functional specifications for the management information system intervention. For these latter tasks, we used the top-down approach.

Appendix G

DISABILITY EVALUATION SYSTEM TRAINING TOPICS FOR PRIMARY PARTICIPANT POPULATIONS ACROSS MILITARY DEPARTMENTS

As noted in Chapter 5, the suggested purpose of the DES and set of desired outcomes shaped the suggested performance competencies for primary participant populations, which in turn shaped the selection of DES topics for training content. Chapter 5 groups the DES topics into six distinct training packages with each containing a specific body of DES knowledge for the relevant primary participant population clusters. In contrast, Table G.1 presents the raw data that served as the basis for the training packages presented in Chapter 5.

Table G.1 contains a comprehensive list of DES topics and our assessment of which primary participant populations require knowledge of a given topic. The topics are listed in the order in which we collected the respective data. This data array informed the organization and development of the content of the six training packages.

We gleaned much of what appears in Table G.1 directly from OSD disability policy documents, augmented by existing military department syllabi and policy documents, and through observation of military department training programs and interviews with primary participants. A few of the topics listed in the table—such as "Difference Between VA and DoD DES"—came directly from our analysis and other recommended interventions noted in this report.

Note: The full range of information included within some knowledge areas is shown in the table in italics. Not all primary participant populations require knowledge in every DES topic area.

Table G.1

Initial Formulation of Disability Evaluation System Topics for Primary Participant Populations

	Primary Participants										
DES Topics	PEBLOs/ Disability Evaluation Coun-selors	Patient Adminis-trators	PEB Adminis-trative Action Officers	Physicians Who Write Narrative Sum-maries	Medical Evalua-tion Board Members	Medical Evaluation Board Approving Author-ities	PEB Members/ Approving Author-ities	Post-PEB Appellate Review Board Mem-bers	Attorneys Who Repre-sent Service Members	Active Compo-nent Unit Com-manders	Reserve Compo-nent Com-manders
References (statutes, directives, instructions)	X	X	X	X	X	X	X	X	X	X	X
Statutory basis of the DES	X	X	X	X	X	X	X	X	X	X	X
DoD DES purpose	X	X	X	X	X	X	X	X	X	X	X
DES desired outcomes	X	X	X	X	X	X	X	X	X	X	X
DES (process and steps)	X	X	X	X	X	X	X	X	X	X	X
Eligibility for referral for full disability adjudication, including checklist to determine eligibility	X		X				X	X	X		
Waiver of DES processing	X		X						X		X
Service member rights, benefits, and entitlements	X						X	X	X		X
Incompetency cases	X	X	X	X	X	X	X	X	X		X
Service member restrictions imposed by the DES	X						X	X	X		X
Effect of PEB findings and decision	X		X				X	X	X		X
Impairment versus disability	X	X	X	X	X	X	X	X	X	X	X
Unfit versus unsuitable (conditions that do not constitute a physical disability)	X	X	X	X	X	X	X	X	X	X	X

Table G.1—Continued

DES Topics	Primary Participants										
	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Medical board coordination among service member, MTF, PEB, and military department personnel organizations	X		X								
Role of primary participants in the DES	X	X	X	X	X	X	X	X	X	X	X
Difference between VA and DoD DES	X			X			X	X	X	X	X
Temporary early retirement authority	X						X		X		
Waiver of disability retirement pay for Reserve retirement	X		X				X	X	X		X
Transfer to the retired Reserve and early qualification for retired pay	X		X				X	X	X		X
Service member election of options	X		X				X	X	X		X
Standards for determination of fitness	X		X				X	X	X		X

Table G.1—Continued

DES Topics	Primary Participants										
	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Compensability Criteria											
15-year rule for early qualification for retired pay for members of the selected Reserve	X		X				X	X	X		X
Proximate result	X		X	X	X	X	X	X	X		
Presumptions of service incurred/aggravated and overcoming presumptions	X		X	X	X	X	X	X	X		
Conditions presumed to be preexisting	X		X	X	X	X	X	X	X		
Noncompliance (refusal of treatment)	X		X	X	X	X	X	X	X		
Compensability Standards											
Prior service impairments	X						X	X	X		X
Reserve component performing duty of 30 days or less	X						X	X	X		X
Permanent limited duty (continuation on active duty or active Reserve status)	X		X				X	X	X	X	X

Table G.1—Continued

DES Topics	Primary Participants										
	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Range of Disability Dispositions											
Fit, return to duty	X	X	X	X	X	X	X	X	X	X	X
Unfit, separate with severance pay	X	X	X	X	X	X	X	X	X	X	X
Unfit, separate without disability benefits	X	X	X	X	X	X	X	X	X	X	X
Unfit, permanent disability retirement	X	X	X	X	X	X	X	X	X	X	X
Unfit, temporary disability retirement list	X	X	X	X	X	X	X	X	X	X	X
TDRL Statutory Requirements											
Retired pay while on TDRL remains constant at 50% to 75% of base pay, although rating may be less	X						X	X	X		
TDRL reevaluations	X	X	X	X	X	X	X	X	X		
Adjudication of TDRL reevaluations	X		X				X	X	X		X

Table G.1—Continued

DES Topics	Primary Participants										
	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Medical Board Contents	X	X	X	X	X	X	X	X	X		
Sufficient narrative summaries	X	X	X	X	X	X	X	X	X		
Appropriate specialty consults	X	X	X	X	X	X	X	X	X		
Comprehensive Clinical Evaluation Protocol	X		X	X	X	X	X	X	X		
LOD determinations (Notice of Eligibility for Navy Reserves)	X	X	X				X	X	X	X	X
Complete physical examination (Standard Form 88/93)	X	X	X	X	X	X	X	X	X		
Appropriate signatures	X	X	X		X	X	X	X	X		
Documents dated within last 90 days	X	X	X	X	X	X	X	X	X		
Medical evidence in case adjudication	X	X	X	X	X	X	X	X	X		
Fact versus opinion	X	X	X	X	X	X	X	X	X	X	X
Purpose of Medical Evaluation Board	X	X	X	X	X	X	X	X	X	X	X

Table G.1—Continued

DES Topics	Primary Participants										
	PEBLOs/ Disability Evaluation Coun-selors	Patient Adminis-trators	PEB Adminis-trative Action Officers	Physicians Who Write Narrative Sum-maries	Medical Evalua-tion Board Members	Medical Evaluation Board Approving Author-ities	PEB Members/ Approving Author-ities	Post-PEB Appellate Review Board Mem-bers	Attorneys Who Repre-sent Service Members	Active Compo-nent Unit Com-manders	Reserve Compo-nent Com-manders
Necessary Medical Data in Sufficient Detail to Enable PEBs to Adjudicate Cases	X	X	X	X	X	X	X	X	X		
Migraine headache cases	X	X	X	X	X	X	X	X	X		
Orthopedic cases (especially backs)	X	X	X	X	X	X	X	X	X		
Neurological/Neurosurgical cases (especially backs)	X	X	X	X	X	X	X	X	X		
Ophthalmologic cases	X	X	X	X	X	X	X	X	X		
Pulmonary cases	X	X	X	X	X	X	X	X	X		
Cardiological cases	X	X	X	X	X	X	X	X	X		
Psychiatric cases (for example, epilepsy, narcolepsy)	X	X	X	X	X	X	X	X	X		
How a service member gets to a Medical Evaluation Board	X	X	X	X	X	X	X	X	X	X	X
Composition (members) of a Medical Evaluation Board	X	X	X	X	X	X	X	X	X		
Retention standards considered by a Medical Evaluation Board	X	X	X	X	X	X	X	X	X		
Documentation of rationale supporting Medical Evaluation Board decision	X		X		X	X	X	X	X		

Table G.1—Continued

DES Topics	Primary Participants										
	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Medical Evaluation Board range of dispositions	X	X	X	X	X	X	X	X	X	X	X
Narrative summary template (contents and format)	X	X	X	X	X	X	X	X	X		
When Specialty Consults Are Required for the Following Conditions and the Diagnostic Details That Are Required											
Fibromyalgia	X	X	X	X	X	X	X	X	X		
Chronic Fatigue Syndrome	X	X	X	X	X	X	X	X	X		
Gulf War Syndrome/ SWATO-related CCEP	X	X	X	X	X	X	X	X	X		
Psychiatric diagnoses/NPT testing for head injury patients	X	X	X	X	X	X	X	X	X		
HIV	X	X	X	X	X	X	X	X	X		
Commander's Letter or Nonmedical Assessment											
Timely response	X	X	X				X	X	X	X	X
Judgment regarding how condition impacts service member's ability to perform duty	X	X	X				X	X	X	X	X

Table G.1—Continued

DES Topics	Primary Participants										
	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Judgment regarding service member's ability to deploy	X	X	X				X	X	X	X	X
Adverse actions pending	X	X	X				X	X	X	X	X
Accepted medical principals	X		X	X	X	X	X	X	X		
Assignment limitation codes/physical profiles	X	X		X	X	X	X		X	X	
Appealing Medical Evaluation Board decisions	X	X		X	X	X			X		
Organization of the VASRD plus supplements (currently 26) and updates	X		X	X	X	X	X	X	X		
Procedure for rating by analogy; use of hyphenated codes in disability adjudication	X						X	X	X		X
Analogous codes (in DoDI 1332.39 and updates) that supplement the VASRD	X		X	X	X	X	X	X	X		
Military department analogous codes that supplement the VASRD and DoDI	X		X	X	X	X	X	X	X		

Table G.1—Continued

DES Topics	Primary Participants										
	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
What it would take to increase percentage of disability determined by the PEB	X						X	X	X		X
Combined ratings/overall effects	X						X	X	X		
Bilateral factor	X						X	X	X		
Pyramiding	X						X	X	X		
Dual processing cases	X		X				X	X	X		
Adjudication of cases involving mental disorders	X		X				X	X	X		
Administrative determinations for purposes of employment under federal civil service	X						X	X	X		
Zero-percent ratings	X						X	X	X		
Disability (separation and retirement) compensation computation	X						X	X	X		X
Documentation of rationale supporting PEB decision	X		X				X	X	X		
Severance pay tax refund	X						X	X	X		
Processing Reserve component non-duty-related cases	X		X				X	X	X		X
Imminent death procedures	X	X	X	X	X	X	X	X	X	X	X

Table G.1—Continued

DES Topics	Primary Participants										
	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Formal PEB presentation	X		X				X	X	X		X
Final administrative disposition of disability separations and retirements	X		X								
Administrative finality	X						X	X	X		
Appeal opportunities	X		X				X	X	X		X
Abuse of discretion	X						X	X	X		
Template for managing disability case appeal									X		
Processing physicians and general officers	X		X				X	X	X		
Potential benefits from the VA	X								X		X
Calculation of effective date of separation or retirement	X		X						X		X
Survivor benefit plan	X										
Acronyms	X	X	X	X	X	X	X	X	X	X	X
Ready Reserves	X	X	X	X	X	X	X	X	X	X	X
Non-duty-related impairment (Reserve component)	X	X	X	X	X	X	X	X	X		
Optimum medical treatment benefits	X	X	X	X	X	X	X	X	X		

Table G.1—Continued

	Primary Participants										
DES Topics	PEBLOs/ Disability Evaluation Counselors	Patient Administrators	PEB Administrative Action Officers	Physicians Who Write Narrative Summaries	Medical Evaluation Board Members	Medical Evaluation Board Approving Authorities	PEB Members/ Approving Authorities	Post-PEB Appellate Review Board Members	Attorneys Who Represent Service Members	Active Component Unit Commanders	Reserve Component Commanders
Preponderance of evidence	X		X	X	X	X	X	X	X		
Administrative determinations for federal tax benefits	X						X	X	X		
Natural progression	X		X	X	X	X	X	X	X		
Presumption of fitness rule and overcoming presumptions	X						X	X	X		

Appendix H

DESCRIPTION OF METRICS FOR ASSESSING DISABILITY EVALUATION SYSTEM PERFORMANCE

This appendix describes the full set of performance metrics proposed in Chapter 6. The metrics described in the first two sections of this appendix focus on the *outcome measures* directly related to the assessment of how well the DES fulfills service member and military service expectations; the metrics described in the last two sections focus on the *output measures* related to the two interventions discussed in Chapter 6—process improvements and enhanced primary participant competency.

METRICS DERIVED FROM SERVICE MEMBER EXPECTATIONS

As described in Chapter 6, two outcome measures—case variability and number of appeals—derive from how well the DES fulfills service member expectations.

Metrics for the Case Variability Outcome Measure

We recommend the following metrics to assess the *case variability* outcome measure: (1) distribution of medical boards by diagnostic category; (2) statistical analysis of dispositions (fitness, rating, and personnel action) for major diagnostic categories; and (3) statistical analysis of dispositions (fitness, rating, and personnel action) for special diagnostic categories (for example, HIV).

These metrics address the relatively aggregate question of whether the military departments are applying disability policy consistently. The distribution of medical boards by diagnostic category is useful primarily for setting the stage or the context for the statistical analyses of dispositions; it also helps to identify the effect of different conditions of service among the military services. The statistical analyses are the primary means of assessing consistent application of disability policy.

The OSD should obtain quarterly data for the metric, *distribution of medical boards by diagnostic category,* using the medical boards sent to the Informal PEB in the previous quarter as a basis for the metric. Each military department's trend serves as the primary benchmark because different conditions of service in each of the departments make comparisons among the departments less meaningful. The data for this metric should be collected using an automated system or a hard copy form included

in the medical board as the Informal and Formal PEBs render a decision on each medical board.

The statistical analyses differ from the other metrics we recommend. These metrics need to be developed because they are not part of the system. We believe an independent organization, such as the DoD Office of the Inspector General, should perform the analysis.[1] We recommend drawing a random sample from medical boards on which the Informal and Formal PEBs rendered decisions in the previous year. To ensure adequate sample sizes, these analyses should be performed only for medical boards from the top five diagnostic categories.

The analysis should test the hypothesis that a difference exists in the dispositions regarding fitness, rating, or personnel action for service members with the same disabling conditions. This hypothesis should be tested within and across military departments. The appropriate benchmarks are military department trends in comparison with the overall DoD standard of no significant difference within or among military departments.

Special diagnostic categories (for example, service members who are diagnosed as HIV-positive) may require a similar analysis of dispositions from time to time. These analyses should be conducted as needed.

Metrics for the Number of Appeals Outcome Measure

We recommend the following metrics for assessing the *number of appeals* outcome measure: (1) percent of Informal PEB decisions appealed for fitness; (2) percent of Informal PEB decisions appealed for rating; (3) percent of Formal PEB decisions appealed for fitness; (4) percent of Formal PEB decisions appealed for rating;[2] and (5) the percent of appeals overturned for each of these categories.

The underlying premise is that the number of appeals serves as a proxy for the level of satisfaction with the process, within a particular part of the DES or for a particular military department. Increasing appeals could suggest growing service member dissatisfaction with the operation of the DES; decreasing appeals could suggest that a military department has implemented a process improvement from which other military departments or other parts of a military department DES could benefit.

The OSD should gather quarterly summary data from the military departments using as a basis medical boards that reflect Informal and Formal PEB decisions rendered in the previous quarter. The appropriate benchmarks are military department trends and comparisons with the overall DoD average. The data for these metrics should be collected using an automated system or a hard copy form included in the medical

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[1] A similar analysis was conducted to support a DoD Inspector General Audit Report on "Medical Disability Discharge Procedures" in June 1992.

[2] For example, for Formal PEB decisions on 100 medical boards, service members appealed four for disagreement with the fitness determination, 27 for disagreement with the rating decision, and 12 for disagreement with both; or, 4, 27, and 12 percent, respectively.

board as the Informal PEB and Formal PEB renders a decision on each medical board.

In addition, because service member perceptions may be as important as empirical data in assessing whether service members *believe* their expectations are being fulfilled, we recommend several other general metrics designed to investigate this outcome measure more directly: percent of service members satisfied with the disposition decision; percent of service members satisfied with the process (timeliness, courtesy, responsiveness, and assistance); percent of service members satisfied that they received due process; number of congressionals (letters written by service members to their representatives in Congress); GAO reports; and IG reports.

We recommend that the OSD develop a DoD-wide survey that the military departments can administer to all service members who complete processing through the DES. The purpose of this survey is to capture the service members' perceptions regarding the first three of these metrics: percent of service members that are satisfied with the disposition decision; percent of service members that are satisfied with the process (timeliness, courtesy, responsiveness, and assistance); and percent of service members that are satisfied that they received due process. Many of the metrics described later in this appendix provide insight into what actually happens with components of the DES that affect service members. The survey will provide a (lagged) link between interventions in the DES and their perceived impact on service members. We recommend a 100-percent survey, with the results analyzed annually. The results should be benchmarked against trends and explicit DoD standards.

Letters from senators and representatives sent to the DoD on behalf of service members generally indicate a significant level of dissatisfaction with the system. Any service member who has exhausted administrative avenues of relief for a perceived injustice and chooses to take his or her case to a member of the Congress has expressed a level of dissatisfaction that deserves special attention. Data for this metric is easy to collect directly within the correspondence management system. We recommend annual assessments, broken out by military department, that are benchmarked against trends and DoD averages.

GAO and IG reports represent ad hoc metrics that can provide additional insight into the DES, and IG reports can be commissioned to focus on particular issues. Like the pleas to members of Congress, these reports may also indicate a certain level of dissatisfaction with the system, although we believe they will be too small in number to draw any conclusions from them.

METRICS DERIVED FROM MILITARY SERVICE EXPECTATIONS

Two general outcome measures derive from how well the DES fulfills service expectations: total system cost and time to replace an unfit service member.

Metrics for the Total System Cost Outcome Measure

We recommend the following metrics for assessing the *total system cost* outcome measure: (1) total resources for the operation of the DES; (2) pay and allowances for service members not performing their duties; and (3) the cost of disability severance pay.

The underlying issue these metrics address is the burden the DES places on a military department. The military departments strive to minimize these costs to be consistent with the goal of accomplishing the purpose of the Disability Evaluation System. We recommend reporting cost data annually and benchmarking the data against trends.

The total resources devoted to operating the DES is an important indicator of how much of a direct burden the DES places on a military department; this metric is important also because it forms the basis of the metrics we recommend for assessing productivity. The total resources metric is an aggregation of pay and allowances or salaries of military and civilian primary participants in the DES; information system costs; training costs; and operations and maintenance costs (other than training and civilian salaries).[3] Pay and allowances for members not performing their duties (those who have entered the DES and been removed from their unit) indicate the opportunity cost of a service member in the DES. The longer the service member remains in the system, the higher the cost. This metric places a value on processing time and allows for a comparison between the total resources devoted to operating the system and the cost of interventions designed to shorten the processing time.

Metrics for the Time to Replace an Unfit Service Member Outcome Measure

We recommend the following metrics for assessing the *time to replace an unfit service member* outcome measure: (1) for service members returned to duty, average total time from referral to an MTF to return to duty; (2) for service members separated or retired, average total time from referral to an MTF to termination; and (3) average total time on the TDRL, broken out by the diagnostic category. We recommend updating each of these metrics quarterly.

These time-to-replace metrics focus on the key contributor to service satisfaction (or dissatisfaction)—the time it takes to replace a service member who is no longer able to function as part of a unit. The metrics address various obstacles that stand in the way of a commander initiating a request for a replacement. Although important to the individual commander, we do not include in the metrics the time it takes to obtain a replacement through the personnel system because that system is not part of the DES.

The first two time-to-replace metrics, *the average time from referral to the military treatment facility until return to duty and the average time from referral to the mili-*

[3]These components of total resources are used as individual metrics when assessing performance measures for enhanced primary participant competencies, as discussed later in this appendix.

tary treatment facility until termination, are computed based on information in the medical board and reported using an automated system or a hard copy form attached to the medical board. These metrics should be broken out by diagnostic category and phase of the DES (Medical Evaluation Board, Physical Evaluation Board, or post-PEB appellate review). Cases in which the service member is returned to duty or terminated or removed from the TDRL in the previous quarter form the basis of the monitored population. The average times are benchmarked against historical trends. A significant increase in the average time to process cases should lead to an investigation of its underlying causes. To accommodate such an activity, the data should be collected in enough detail to allow for an inspection of the distribution of processing times.

We recommend similar metrics for service members placed on limited duty. Several primary participants and other officials we interviewed expressed concern with the number of service members placed on limited duty, both before and after being referred to the DES. In recognizing that the limited duty determination is not a part of the DES, we recommend a metric that separately monitors the distribution of time on limited duty before and after referral to the DES, with an eye toward ensuring that the referral is accomplished at the appropriate time.

METRICS RELATED TO ENHANCING PRIMARY PARTICIPANT COMPETENCY

Three general output measures capture the effect of interventions targeted at enhancing primary participant competencies: productivity, cost per medical board decision, and percent of primary participants certified. The input measure, total resources, augments the output measures.

Metrics for the Productivity Output Measure

We recommend the following metrics for assessing the *productivity* output measure: (1) medical board decisions rendered per Informal PEB member; (2) medical board decisions rendered per Formal PEB member; (3) medical board processing completed per full-time PEBLO and PEB administrative action officer assigned to the PEB; (4) primary participant satisfaction, by primary participant population; and (5) turnover, by primary participant population.

These metrics provide insight into the effectiveness of primary participants in the system. For example, declining productivity should theoretically lead to decreased service member and service satisfaction. Monitoring this metric and acting upon changes enables leaders to implement corrective action in time to head off decreased satisfaction. In other words, productivity is a leading indicator of service member and service satisfaction.

Metrics for the other two output measures for enhancing primary participant competency, *cost per medical board decision* and *percent of primary participants certified,* and the input measure *total resources devoted to the Disability Evaluation*

System, are leading performance indicators foretelling change in the lagging indicator *productivity*, and suggest where interventions may be most effective.

For the first three productivity metrics, the military departments should pull data from Informal and Formal PEB decisions rendered and total medical boards processed in the previous quarter together with current manning (staffing) data and report the summary results quarterly. The results should be represented as the quotient of the number of decisions rendered in the previous quarter and the average number of Informal PEB members, Formal PEB members or full-time PEBLOs, and PEB administrative action officers. These metrics should be benchmarked against trends and DoD averages.

The fourth and fifth productivity metrics—*primary participant satisfaction by primary participant population* and *turnover by primary participant population*—are interrelated, with turnover being a manifestation of the level of satisfaction in some cases. We recommend an annual 100-percent survey of primary participant satisfaction, summarized by primary participant populations (specifically, Medical Evaluation Board members and approving authorities, PEBLOs, PEB administrative action officers, and approving authorities). The surveys should probe for the source of satisfaction or dissatisfaction through structured multiple-choice questions, and solicit suggestions for ways to improve the operation of the system through open-ended questions. Summary statistics on the level of satisfaction or dissatisfaction and their underlying causes should be reported to the OSD. These metrics should be benchmarked against trends.

Turnover statistics should be reported annually and expressed in terms of the percent of primary participants (by population) assigned to positions supporting the DES at the beginning and end of the previous year. The data should be derived from unit manning documents. This metric should be benchmarked against trends. As suggested earlier, primary participant satisfaction is a leading indicator of turnover rates; a decrease in the former affords the opportunity to apply interventions designed to stem the latter (particularly if the cause of dissatisfaction can be identified).

Metrics for the Cost Per Medical Board Decision Output Measure

We recommend total system cost divided by total Informal and Formal PEB decisions rendered as the metric for assessing the *cost per medical board decision* output measure. Military departments should report this metric to the OSD annually, based on the obligated resources and the medical board decisions rendered in the previous year.

The total system cost should be derived from budget data; the number of medical board decisions rendered should be captured from an automated system or from a hard copy form accompanying the medical boards. We recognize that this metric does not provide an entirely accurate characterization of the cost per medical board

decision.[4] However, in the absence of dramatic changes in obligated resources or in the number of medical board decisions rendered in a particular year, the metric provides a reasonable indicator of cost per medical board decision. This is the primary reason we recommend an annual report, as opposed to more-frequent reports. Trends should be the benchmark for this metric with the objective of continually decreasing the cost per medical board decision over time.

Metrics for the Percent of Primary Participants Certified Outcome Measure

We recommend the following metrics for assessing the *percent of primary participants certified* outcome measure: (1) percent of commanders' letters submitted by number of certified commanders; (2) percent of medical boards dictated by number of certified physicians; (3) percent of PEBLOs certified; (4) percent of Informal PEB members certified; (5) percent of Formal PEB members certified; and (6) percent of PEB administrative action officers certified.

As noted in Chapter 5, we believe that certification of the primary participants is key to accomplishing the purpose of the DES. As a result, these metrics should be benchmarked against both trends and demanding DoD standards. We recommend the military departments provide these metrics quarterly.

As also noted in Chapter 5, we recommend that commanders and physicians become certified through their respective just-in-time distance training packages available from an OSD Web site. This will provide the opportunity for nearly 100-percent certification within the quarterly reporting time frame. Periodic training for PEBLOs, PEB members, and administrative action officers, if scheduled as it is currently, may result in lower rates of certification because of the limited scheduling of training opportunities. Reporting these certification metrics quarterly, however, will indicate whether the infrequency of training opportunities is a significant problem (as it may be for annual training and high personnel turnover) calling for an intervention.

For the first two metrics for this outcome measure, the commanders submitting letters and the physicians dictating boards should self-report whether they are certified. This information should be captured in an automated system or on a hard copy form accompanying the medical board when it arrives at the Informal PEB. We found that incomplete commanders' letters and incomplete narrative summaries are two of the current major causes of delay in the DES. Associating the data from specific commanders or physicians with the respective medical board will allow the military departments to assess whether noncertified commanders and physicians materially contribute to delays in the system and, similarly, whether the training leading to certification is accomplishing its purpose.

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[4]PEB decisions rendered on medical boards in a particular year may have begun in a previous year (and used resources obligated for that time frame). Similarly, the PEBs may begin considering a medical board in a particular year but may not render a decision in that year (and will use resources obligated for that time frame but attributed to completed cases). Consequently, significant increases or decreases in this metric in a particular year should first be reviewed in terms of a potential anomaly in the obligated resources or the medical board decisions rendered in that year.

For the four other metrics for this outcome measure, we recommend that the military departments obtain and aggregate the data from personnel records. In these cases, individuals act collectively to process medical boards. Consequently, the overall level of certification is a more important measure than individual certification data.[5]

Metrics for the Total Resources Input Measure

We recommend the following metrics for assessing the sole input measure, *total resources*: (1) number of individuals broken out by DES phase or primary participant population devoted to the DES; (2) pay and allowances or salaries of individuals broken out by phase or primary participant population devoted to the DES; (3) information management system costs; (4) training costs; and (5) operations and maintenance costs (other than training and civilian salaries).

Although the total level of resources is important as an indicator of the resource burden the DES places on a military department, how those resources are allocated to the various phases of the DES influences system performance more directly. We structure the metrics in this area accordingly.

The military departments should report total resources devoted to the DES by major budget areas and phases of the system. For the Medical Evaluation Board phase, training costs are the key metric. For the PEB phase, the metric should include pay and allowances for military primary participants, civilian salaries, training, and information system procurement.

We recommend preparing annual performance reports, extracted from budget data, for both the previous year and for the upcoming budget year. These metrics should be benchmarked against trends. The resources allocated in the budget reflect a commitment to future performance objectives. Based on that financial commitment together with intended interventions, the military departments should provide performance objectives for other performance measures (for example, productivity, cost per medical board decision, percent of primary participants certified, and processing time).

METRICS RELATED TO THE PROCESS IMPROVEMENT INTERVENTION

Three general output measures capture the impact of actions targeted at the process improvement intervention: processing time, number of reworks, and time to promulgate policy changes.

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[5]Because PEBLOs handle individual medical boards, for *the percent of PEBLOs certified* metric we considered indicating on each medical board whether the PEBLO handling it was certified. We did not recommend that approach primarily because a PEBLO may become certified during the time in which he or she is handling the case, confusing whatever impact certification may have.

Metrics for the Processing Time Output Measure

We recommend the following metrics for assessing the *processing time* output measure: (1) distribution of waiting times for narrative summary dictation (time from referral to the MTF to dictation of the narrative summary or to the service member being returned to duty); (2) distribution of waiting times for Informal PEB consideration (time from dictation of narrative summary to Informal PEB decision); (3) distribution of waiting times for Formal PEB consideration (time from Informal PEB decision to Formal PEB decision); and (4) distribution of waiting times for decision by post-PEB appellate review boards (time from Formal PEB decision to final decision by highest-level in-service appellate review).

Although average processing time can and should be calculated and reported, the distribution of waiting times provides significantly more information on performance. We recommend breaking out the separate phases of the system (including levels within phases, such as the Informal and Formal PEB levels in the physical disability evaluation phase) to better identify the potential need for targeted interventions. The waiting times should be computed based on the event that sends a medical board to the next phase or level in the DES process without regard for whether the medical board is returned or delayed because of incomplete information.[6] (The metrics associated with the next performance measure—number of reworks—focus on medical boards returned to an earlier phase or level in the process.)

The processing-time metrics should be reported quarterly by diagnostic category based on medical board decisions rendered at each level during the previous quarter. They should be benchmarked against trends and DoD standards. The data to develop these metrics should be captured in an automated system or on a hard copy form that accompanies the medical board.

Metrics for Number of Reworks Output Measure

We recommend the following metrics for assessing the *number of reworks* output measure: (1) percent of deficient commanders' letters at Informal PEBs, by reason; (2) percent of deficient commanders' letters at Formal PEBs, by reason; (3) percent of deficient narrative summaries at Informal PEBs, by reason; (4) percent of deficient narrative summaries at Formal PEBs, by reason; (5) percent of incomplete medical boards at Informal PEBs, by reason; and (6) percent of incomplete medical boards at Formal PEBs, by reason.

We recommend a particular focus on commanders' letters, narrative summaries, and medical boards because, as noted earlier, numerous primary participants identified these items as a source of delay. The reasons for deficiencies will help to focus on the appropriate interventions to, for example, modify training content related to primary participant certification. We do not recommend employing metrics related to the

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[6]For example, the time period from when a medical board is returned to the MTF from the Informal PEB because of an insufficient narrative summary should be counted against the waiting time for Informal PEB consideration.

amount of delay that reworks cause because the focus should be on eliminating the need for reworks, regardless of how long a particular rework delays the overall process.

The reworks metrics should be reported quarterly based on medical board decisions rendered at each DES phase and level during the previous quarter. They should be benchmarked against trends. The data to develop these metrics should be captured in an automated system or on a hard copy form that accompanies the medical board.

Metrics for the Time to Promulgate Policy Changes Output Measure

We recommend the following metrics for assessing the *time to promulgate policy changes* output measure: (1) time to transmit information to the field; (2) time to update military department policy documents; and (3) time to update training. These metrics primarily address the source of variation among military departments.

Rather than suggesting the military departments report these metrics at fixed intervals, we recommend that the military departments' Secretariat send a letter confirming the promulgation of policy in each of these three metrics. The OSD should develop the target metric for promulgating policy based on military department responses. These time to promulgate policy change metrics should be benchmarked against military department trends and the DoD average.

Appendix I

COST-BENEFIT ANALYSIS DATA

This appendix contains military department data, shown in Tables I.1 through I.7, that were used to develop the training cost-benefit analysis discussed in Chapter 7 of this report.

Table I.1

Training Populations

Population	Department of the Army			Department of the Navy			Department of the Air Force		
	Initial Number Trained	Ongoing Number Trained	Average Grade	Initial Number Trained	Ongoing Number Trained	Average Grade	Initial Number Trained	Ongoing Number Trained	Average Grade
PEBLOs	38	10	GS7	11	4	E-7	118[a]	38	E-4
Disability Counselors	N/A	N/A	N/A	26	7	E-5	N/A	N/A	N/A
Patient Administrators[b]	76	28	E-5	70	23	E-5	59	19	E-5
PEB and Post-PEB Appellate Review Board Members	23	8	O-6	17	6	O-6	11	4	O-6
PEB Action Officers	9	3	GS7	9	3	GS7	10	3	GS7
Physicians[c]	95% of case load	85% of case load	O-3	95% of case load	85% of case load	O-3	95% of case load	85% of case load	O-3
Commanders	Total case load	Total case load	O-3	Total case load	Total case load	O-3	Total case load	Total case load	O-3

[a]Includes 59 PEBLOs and 59 PEBLO backups, usually patient administrators.

[b]For the Department of the Army, we assume each PEBLO will be assisted by two patient administrators. For the Department of the Navy, we assume that four patient administrators assist each PEBLO and one patient administrator assists each disability evaluation counselor. For the Department of the Air Force, we assume that one patient administrator assists each PEBLO because the Air Force also trains patient administrators to back up PEBLOs.

[c]Physicians include those who dictate narrative summaries as well as Medical Evaluation Board members and approving authorities.

Table I.2

Department of the Army Opportunity Cost of Self-Directed Computer-Based Distance Training

Year	PEBLOs	Patient Administrators	Commanders	PEB Administrative Officers	PEB/Post-PEB Appellate Review Board Members	Physicians	Total Cost	NPV Cost
0	—	—	—	—	—	—	—	—
1	$26,144	$6,840	$195,554	$5,160	$26,956	$743,106	$1,003,760	$938,094
2	$6,880	$2,520	$195,554	$1,720	$9,376	$664,884	$880,935	$769,442
3	$6,880	$2,520	$195,554	$1,720	$9,376	$664,884	$880,935	$719,105
4	$6,880	$2,520	$195,554	$1,720	$9,376	$664,884	$880,935	$672,061
5	$6,880	$2,520	$195,554	$1,720	$9,376	$664,884	$880,935	$628,094
Total	$53,664	$16,920	$977,771	$12,040	$64,460	$3,402,644	$4,527,499	$3,726,797

Table I.3

Department of the Navy Opportunity Cost of Self-Directed Computer-Based Distance Training

Year	PEBLOs	Disability Evaluation Counselors	Patient Administrators	Commanders	PEB Administrative Officers	PEB/Post-PEB Appellate Review Board Members	Physicians	Total Cost	NPV Cost
0	—	—	—	—	—	—	—	—	—
1	$5,368	$9,360	$6,300	$228,116	$5,160	$19,924	$866,842	$1,141,070	$1,066,421
2	$1,952	$2,520	$2,070	$228,116	$1,720	$7,032	$775,595	$1,019,006	$890,039
3	$1,952	$2,520	$2,070	$228,116	$1,720	$7,032	$775,595	$1,019,006	$831,812
4	$1,952	$2,520	$2,070	$228,116	$1,720	$7,032	$775,595	$1,019,006	$777,394
5	$1,952	$2,520	$2,070	$228,116	$1,720	$7,032	$775,595	$1,019,006	$726,537
Total	$13,176	$19,440	$14,580	$1,140,581	$12,040	$48,052	$3,969,223	$5,217,092	$4,292,203

Table I.4

Department of the Air Force Opportunity Cost of Self-Directed Computer-Based Distance Training

Year	PEBLOs	Patient Administrators	Commanders	PEB Administrative Officers	PEB/Post-PEB Appellate Review Board Members	Physicians	Total Cost	NPV Cost
0	—	—	—	—	—	—	—	—
1	$35,400	$5,310	$76,687	$3,440	$12,892	$291,410	$425,138	$397,326
2	$11,400	$1,710	$76,687	$1,032	$4,688	$260,735	$356,252	$311,164
3	$11,400	$1,710	$76,687	$1,032	$4,688	$260,735	$356,252	$290,808
4	$11,400	$1,710	$76,687	$1,032	$4,688	$260,735	$356,252	$271,783
5	$11,400	$1,710	$76,687	$1,032	$4,688	$260,735	$356,252	$254,003
Total	$81,000	$12,150	$383,434	$7,568	$31,644	$1,334,349	$1,850,145	$1,525,082

Table I.5

Department of the Army Quantifiable Benefits

	Medical Evaluation Board Phase			Physical Disability Evaluation Board Phase				
Year	TDRL Fit	TDRL Separate	Active	TDRL Fit	TDRL Separate	Active	Total Year	NPV Benefit
0	—	—	—	—	—	—	—	—
1	$3,787	$12,401	$612,873	$941	$3,083	$152,343	$785,427	$734,044
2	$5,410	$17,716	$875,533	$1,569	$5,138	$253,905	$1,159,269	$1,012,550
3	$5,410	$17,716	$875,533	$1,569	$5,138	$253,905	$1,159,269	$946,309
4	$5,410	$17,716	$875,533	$1,569	$5,138	$253,905	$1,159,269	$884,401
5	$5,410	$17,716	$875,533	$1,569	$5,138	$253,905	$1,159,269	$826,543
Total	$25,425	$83,263	$4,115,005	$7,216	$23,633	$1,167,961	$5,422,503	$4,403,847

Table I.6

Department of the Navy Quantifiable Benefits

	Medical Evaluation Board Phase			Physical Disability Evaluation Board Phase				
Year	TDRL Fit	TDRL Separate	Active	TDRL Fit	TDRL Separate	Active	Total Year	NPV Benefit
0	—	—	—	—	—	—	—	—
1	$7,271	$23,798	$975,946	$6,924	$13,599	$557,684	$1,582,451	$1,478,926
2	$10,386	$33,996	$1,394,209	$6,924	$22,664	$929,473	$2,397,653	$2,094,203
3	$10,386	$33,996	$1,394,209	$6,924	$22,664	$929,473	$2,397,653	$1,957,199
4	$10,386	$33,996	$1,394,209	$6,924	$22,664	$929,473	$2,397,653	$1,829,158
5	$10,386	$33,996	$1,394,209	$6,924	$22,664	$929,473	$2,397,653	$1,709,493
Total	$48,816	$159,783	$6,552,781	$31,852	$104,256	$4,275,574	$11,173,062	$9,068,979

Table I.7

Department of the Air Force Quantifiable Benefits

	Medical Evaluation Board Phase			Physical Disability Evaluation Board Phase				
Year	TDRL Fit	TDRL Separate	Active	TDRL Fit	TDRL Separate	Active	Total Year	NPV Benefit
0	—	—	—	—	—	—	—	—
1	$1,495	$4,890	$166,860	$338	$1,106	$37,749	$212,438	$198,540
2	$2,144	$7,015	$166,860	$564	$1,106	$62,914	$313,828	$274,110
3	$2,144	$7,015	$166,860	$564	$1,106	$62,914	$313,828	$256,177
4	$2,144	$7,015	$166,860	$564	$1,106	$62,914	$313,828	$239,418
5	$2,144	$7,015	$166,860	$564	$1,106	$62,914	$313,828	$223,755
Total	$10,017	$32,949	$1,124,251	$2,592	$8,482	$289,406	$1,467,751	$1,192,000

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& for Improving Performance of the Department of Defense Disability Evaluation System

The Disability Evaluation System (DES) is a management tool used by the Department of Defense to determine the disposition of a service member who has a medical condition that calls into question the member's ability to perform his or her duties. The DES exists to evaluate service members with such medical conditions, remove those unable to fulfill their duties, and determine a disability rating for those who are removed. This book focuses on four major research tasks related to improving system performance: developing a basis for assessing DES outcomes, identifying issues of variability in DES policy application, conducting a DES training analysis and presenting recommended changes, and developing a method for continuously monitoring DES performance. As part of their findings, the authors constructed a set of desired system outcomes and from that framework suggest comprehensive training and information management interventions to improve overall system performance. The authors also identify groups of primary DES participants and outline the specific bodies of knowledge and skills the participants require to execute disability policy consistently throughout the military departments.

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